MINISTRY OF HEALTH AND MINISTRY RESPONSIBLE FOR SENIORS

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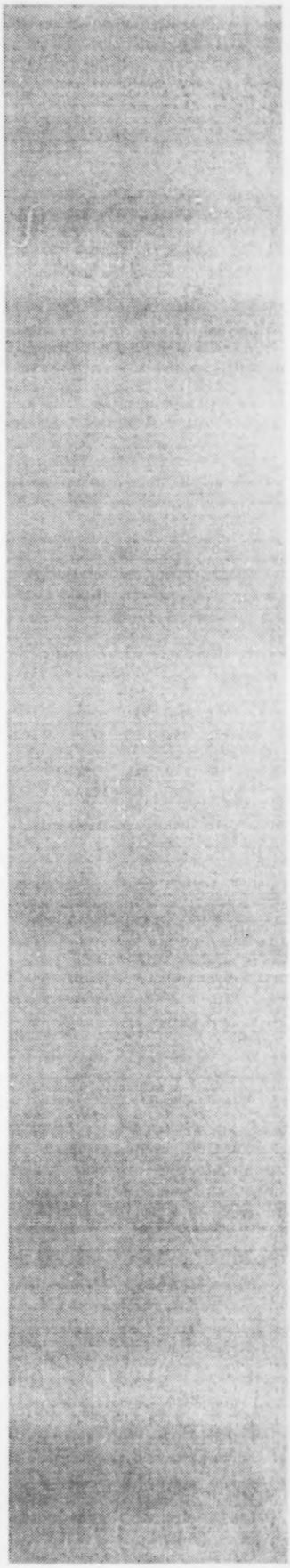


Office of the Minister of Health
and Minister Responsible for Seniors
Parliament Buildings
Victoria, British Columbia

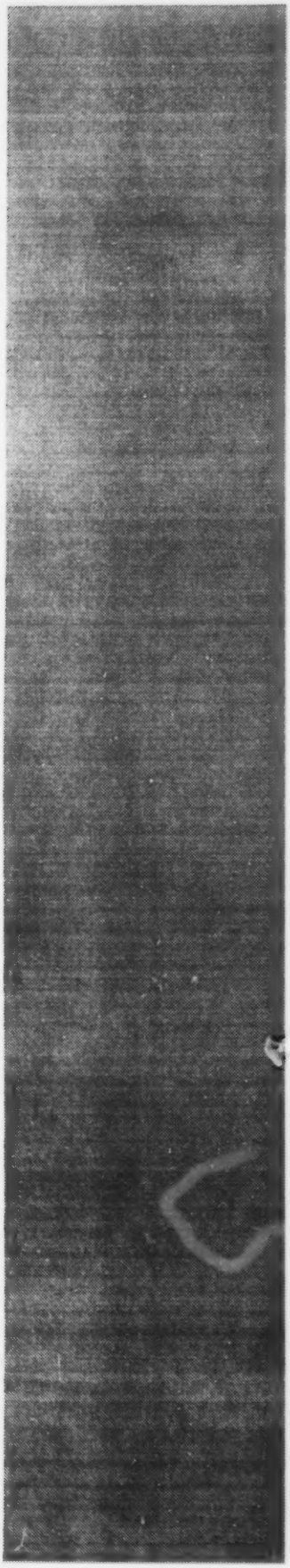
May 16, 2000

The Honourable Garde Gardom
Lieutenant-Governor of the Province of British Columbia

May it please your Honour:

The annual report of the Ministry of Health and Ministry Responsible for Seniors for 1998/99 is herewith respectfully submitted.

Michael Farnworth
Minister of Health and Minister Responsible for Seniors



Ministry of Health and
Ministry Responsible for Seniors
Parliament Buildings
Victoria, British Columbia

May 16, 2000

The Honourable Michael Farnworth
Minister of Health and Minister Responsible for Seniors
Victoria, British Columbia

Minister:

I have the honour of submitting the annual report of
the Ministry of Health and Ministry Responsible for Seniors
for 1998/99.

Leah Hollins
Deputy Minister

100-05604

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MINISTER'S MESSAGE

This annual report sets a new standard for openness and accountability in our health system. For the first time ever, the Ministry of Health's annual report goes far beyond the usual practice of describing the ministry, listing government accomplishments and presenting financial statements.

This report is designed to be more relevant to the people who pay for and use our health care system. It reports on what was actually happening in our health system during 1998/99 – the services that were provided and the effect they had on people's health. Through a variety of performance measures, this report gives a sense of our health system's strengths and the challenges that it faces.

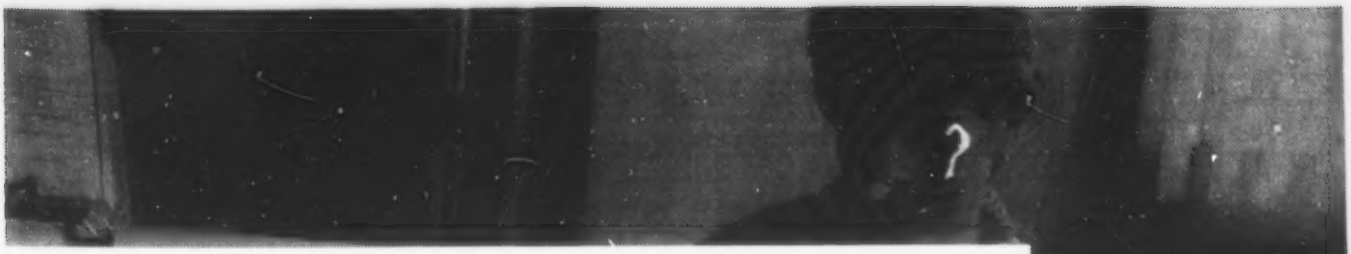
British Columbians are proud of our publicly funded health care system, are concerned about where it's headed and are counting on us to protect and improve health services. They want a health system that meets their personal and families' needs and will be sustainable long into the future. They want pressure on B.C. hospitals to be relieved. They want us to show that we are directing precious health resources where they will make the greatest possible difference to people's health.

We are up to that challenge. Our government is committed to ensuring that patients receive the right care at the right time in the right place, but we can't and aren't trying to do it all on our own. We are working with all our health care partners – health authorities, practitioners, frontline workers and others – to protect and improve publicly funded health care for all British Columbians.

To make sure we achieve this, we have an obligation to tell British Columbians how their tax dollars are making a difference in meeting health care needs and improving overall health. We also have an obligation to use this information to improve how we meet the needs of B.C. patients. This report is a step toward fulfilling that important responsibility.

Honourable Michael Farnworth
Minister of Health and Minister Responsible for Seniors

WE ARE WORKING WITH ALL OUR HEALTH CARE PARTNERS – HEALTH AUTHORITIES, PRACTITIONERS, FRONTLINE WORKERS AND OTHERS – TO PROTECT AND IMPROVE PUBLICLY FUNDED HEALTH CARE FOR ALL BRITISH COLUMBIANS.



INTRODUCTION

British Columbians consider health care to be a top priority of government, and this is reflected in the province's significant funding commitment to health services and programs. This report is designed to present information on what taxpayers are getting for their investment in health care.

This annual report marks a major step forward for the Ministry of Health in its continuing effort to increase the amount and quality of information provided to the Legislature and the people of British Columbia. For the first time, this report provides extensive information on the performance of the ministry and our health system.

The performance measures provided in this report are intended to give a sense of how successfully the ministry and our health system is fulfilling the province's goals in the areas of health care accessibility, quality, affordability and sustainability, and contributing to overall good health.

This report includes three main sections: the structure of the ministry, key areas of performance and ministry key events.

The structure section gives a very brief description of the ministry's various divisions and offices, in order to help readers understand how the ministry is organized.

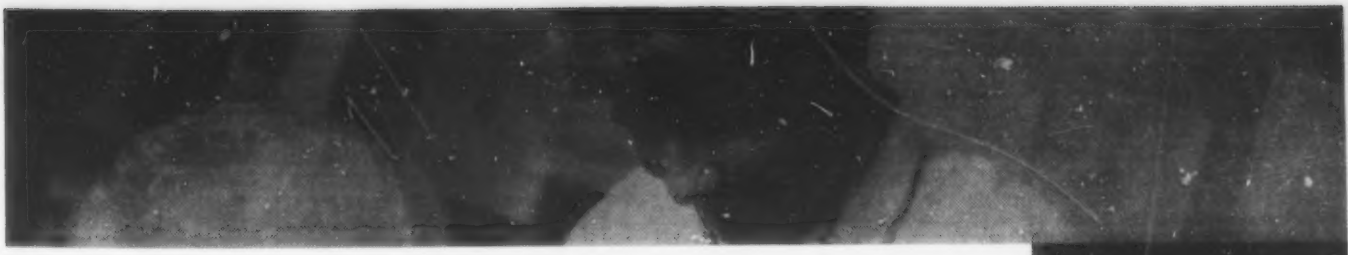
The performance section presents a selection of measures intended to convey the state of British Columbia's publicly funded health care system in 1998/99. These measures provide a picture of health, health care and the Ministry of Health in 1998/99.

The key events section summarizes many of the significant events that took place during 1998/99, with an emphasis on ministry initiatives.

The information presented in the performance section summarizes much more detailed data that has been collected by the ministry in preparation for this document.

Because this report is intended for a general audience, extensive footnoting and detailed lists of sources are not included here. However, this information is referenced in background material that is available from the ministry.

THIS REPORT IS DESIGNED TO PRESENT INFORMATION ON WHAT TAXPAYERS ARE GETTING FOR THEIR INVESTMENT IN HEALTH CARE

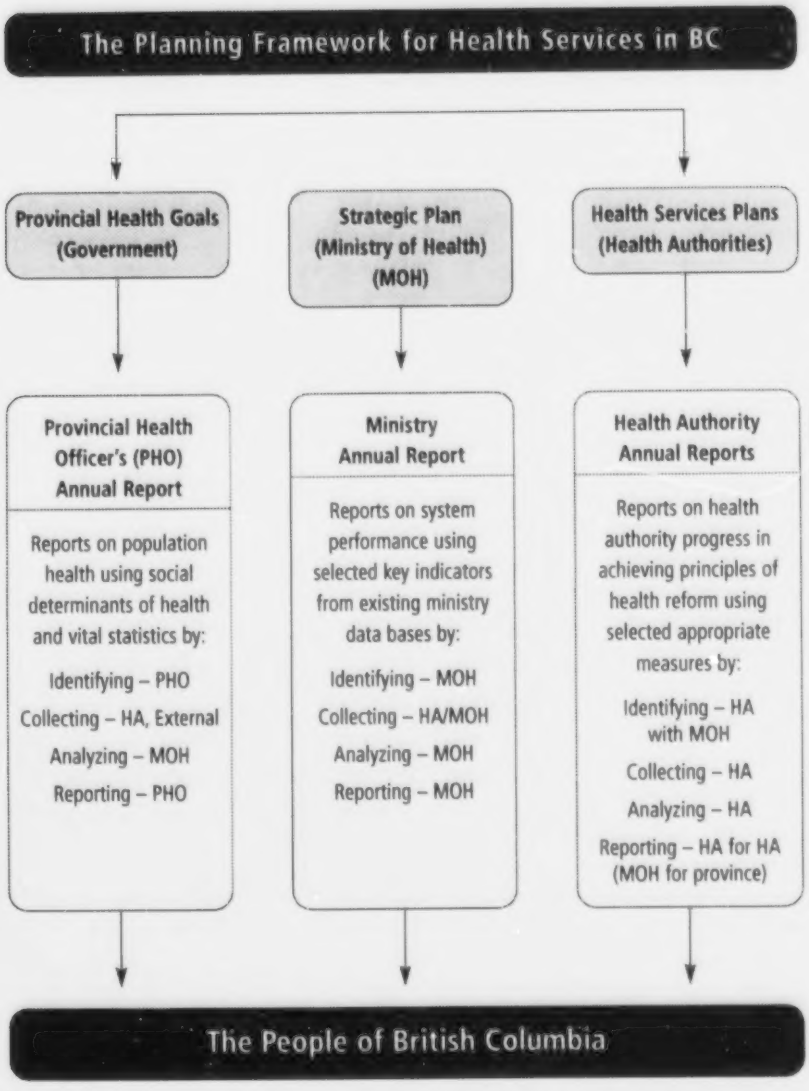


REPORTING IN A STRATEGIC ENVIRONMENT

This report covers a period during which the Ministry of Health was embarking on the development of a comprehensive planning framework for health services in B.C. Although the ministry's 1999-2002 Strategic Directions plan was completed after the end of the 1998/99 fiscal year, this annual report is an important first step in linking the ministry's annual reports with the strategic planning process.

As the following chart indicates, the ministry annual report is one of three types of documents that report on progress in achieving the province's health goals. The other two are the annual reports of the Provincial Health Officer and health authorities.

The Planning Framework for Health Services in BC


Provincial Health Goals (Government)
Strategic Plan (Ministry of Health) (MOH)
Health Services Plans (Health Authorities)
Provincial Health Officer's (PHO) Annual Report
Reports on population health using social determinants of health and vital statistics by:
Identifying – PHO
Collecting – HA, External
Analyzing – MOH
Reporting – PHO
Ministry Annual Report
Reports on system performance using selected key indicators from existing ministry data bases by:
Identifying – MOH
Collecting – HA/MOH
Analyzing – MOH
Reporting – MOH
Health Authority Annual Reports
Reports on health authority progress in achieving principles of health reform using selected appropriate measures by:
Identifying – HA with MOH
Collecting – HA
Analyzing – HA
Reporting – HA for HA (MOH for province)
The People of British Columbia

Source: Strategic Directions for British Columbia's Health Services System. 1999

MINISTRY MISSION STATEMENT

The mission of the Ministry of Health is to support British Columbians in their efforts to maintain and improve their health. The ministry provides strategic direction and leadership of the health care system on behalf of the provincial government. Through a broad range of programs, services and public funding, the ministry is responsible for ensuring the maintenance of high quality, accessible, affordable health care for British Columbians.

STRUCTURE OF THE HEALTH SYSTEM

In Canada, the federal government has established overarching legislation that sets out the health care roles and responsibilities of governments. The *Canada Health Act* and the *Food and Drug Act* are examples of key pieces of federal health care legislation. The federal government provides health care funding through transfers to the provinces and has responsibility for regulating the safety of food and drugs, medical devices and various other health care products. In addition, the federal government has responsibility for some aspects of surveillance and public health.

British Columbia, like other provinces, has responsibility for health care funding and the delivery of a vast array of services, by a variety of providers, and in a variety of settings. These services include those wholly part of our publicly-funded health system as well as services that the government only supports in part or services that government does not support financially but regulates.

The Ministry of Health 1998/99 budget was increased by $228.5 million bringing the total government health spending to $7.4 billion, an increase of nearly 2 billion or 33 percent since 1991/92.

British Columbia has a progressive, integrated health care system that relies on a regional delivery system and self-regulating professional colleges to support quality and a commitment to standards. Although the Ministry of Health has ultimate authority and responsibility for our publicly administered health care system, responsibility for the direct delivery and management of many health care services rests with health authorities. These authorities include 11 Regional Health Boards (RHBs), 34 Community Health Councils (CHCs), and seven Community Health Services Societies (CHSSs) across the province.

The government of B.C. is responsible legislatively for all aspects of the provincial health care system, including the regionalized delivery system, self-regulating professional colleges and various direct delivery programs.

Our health care system's regional structure is set out in maps included in appendices to this report:

- Regional Health Boards (see the map in Appendix 7, page 74);
- Community Health Councils (see the map in Appendix 8, page 75);
- Community Health Services Societies (see the map in Appendix 9, page 76).

ALTHOUGH THE MINISTRY OF HEALTH HAS ULTIMATE AUTHORITY AND RESPONSIBILITY FOR OUR PUBLICLY ADMINISTERED HEALTH CARE SYSTEM, RESPONSIBILITY FOR THE DIRECT DELIVERY AND MANAGEMENT OF MANY HEALTH CARE SERVICES RESTS WITH HEALTH AUTHORITIES

ACUTE AND CONTINUING CARE

Acute and Continuing Care is responsible for assisting health authorities to provide accessible, high quality and responsive health services. This is done by assisting health authorities with planning, identification of emerging issues, and supporting quality improvement initiatives.

The division provides funding for and monitors the delivery of acute care services and continuing care services across the province. Its mandate is to ensure a coordinated acute, specialized, continuing and community care delivery system that provides all B.C. residents with reasonable access to necessary health care services of appropriate quality at an affordable and sustainable cost.

Since the regionalization of British Columbia's health care system, Acute and Continuing Care has been the primary point of contact for health authorities for funding and policy direction relating to health services delivered in institutional and community settings, including mental health and other community-based programs. Four teams, each of which has responsibility for supporting an identified group of health authorities in one geographic area of the province. These teams collaborate with health authorities, external service providers, industry and other stakeholders in the development of policy, operating standards, accountability structures, monitoring and review, and evaluation of the health system.

Other functions include preparing budget allocations for health authorities and reviewing health authorities' budgets, providing operating and equipment funding for health authorities, managing contracts for tertiary health services, and preparing a capital budget in conjunction with the Ministry of Finance and Corporate Relations.

THE DIVISION'S MANDATE IS TO ENSURE A COORDINATED ACUTE, SPECIALIZED, CONTINUING AND COMMUNITY CARE DELIVERY SYSTEM THAT PROVIDES ALL B.C. RESIDENTS WITH REASONABLE ACCESS TO NECESSARY HEALTH CARE SERVICES OF APPROPRIATE QUALITY AT AN AFFORDABLE AND SUSTAINABLE COST

The British Columbia Ambulance Service

The British Columbia Ambulance Service (BCAS) provides public ambulance service in British Columbia. With approximately 3,300 employees, the BCAS provides emergency and non-emergency ambulance responses to approximately 385,000 ground calls and performs an additional 6,000 aeromedical evacuations each year.

Service is provided through 196 ambulance stations, three regional dispatch centres, an air ambulance dispatch centre and four regional administrative offices in addition to provincial headquarters in Victoria.

COMMUNITY HEALTH

Community Health includes the following divisions: Public and Preventive Health, Aboriginal Health, HIV/AIDS, Forensic Psychiatric Services and Adult Mental Health.

Public and Preventive Health

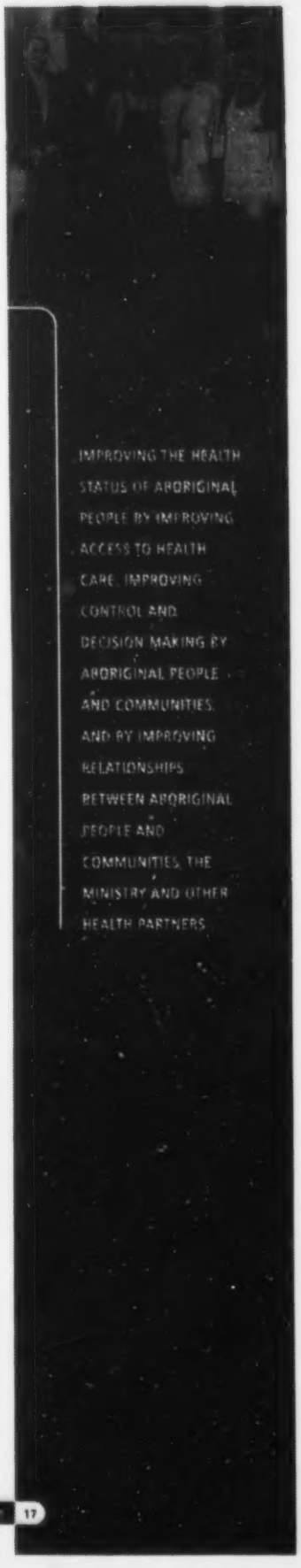
The mission of the **Public and Preventive Health Division** is to fulfill a leadership and policy development role that will enable individuals and communities to achieve and maintain an environment free of significant health and safety hazards, achieve a healthier society by the prevention and control of disease, and ensure the well being of people living in licensed community care facilities. The Public and Preventive Health Division provides for the management and operation of public and preventive health programs, including: British Columbia Centre for Disease Control Society, Community Care Facilities Branch, Preventive Health Branch, Program Support and Accountability Branch, Public Health Protection Branch, and Radiation Protection Branch.

The **Aboriginal Health Division** has primary responsibility for the ministry's relationship with the Aboriginal community. This includes negotiation, consultation, and contract management. As well, the division is responsible for providing policy direction and advice to the ministry. Managing the relationship with different ministries, different departments within the federal government, as well as local health authorities and other health partners, the division provides advice, support, and assistance on Aboriginal health matters. The overall mission of the division is to work toward improving the health status of Aboriginal people by improving access to health care, improving control and decision making by Aboriginal people and communities, and by improving relationships between Aboriginal people and communities, the ministry and other health partners.

The **HIV/AIDS Division** provides leadership and guides the implementation of *British Columbia's Framework for Action on HIV/AIDS* in collaboration with key stakeholders including representatives of the HIV/AIDS community, health authorities, other ministries and governments. The division administers funds totalling over $11 million for community based HIV/AIDS services provided by over 50 HIV/AIDS organizations and needle exchanges including Aboriginal specific grants.

The **Forensic Psychiatric Services Commission** is responsible for the assessment, treatment and clinical case management of mentally disordered persons who are in conflict with the law. Specifically, the Forensic Psychiatric Services Commission is mandated under the *Forensic Psychiatry Act* to:

- provide forensic psychiatric services to the courts;
- provide forensic psychiatric services, including in-patient and out-patient treatment for accused persons remanded for psychiatric examination, persons held at the direction of the B.C. Review Board, persons in need of psychiatric care or assessment while in custody and persons held under a court order;
- plan, organize and conduct research and educational programs respecting the diagnosis, treatment and care of forensic psychiatric clients; and
- consult with all levels of government, mental health centres, and related agencies regarding the advancement of the Commission's objectives.



IMPROVING THE HEALTH STATUS OF ABORIGINAL PEOPLE BY IMPROVING ACCESS TO HEALTH CARE, IMPROVING CONTROL AND DECISION MAKING BY ABORIGINAL PEOPLE AND COMMUNITIES, AND BY IMPROVING RELATIONSHIPS BETWEEN ABORIGINAL PEOPLE AND COMMUNITIES, THE MINISTRY AND OTHER HEALTH PARTNERS

The Forensic Psychiatric Institute in Port Coquitlam admits persons who are remanded by the courts for a psychiatric assessment to determine whether they are fit to stand trial, or whether, at the time of their offence, they were suffering from a mental disorder rendering them not criminally responsible. Persons found unfit to stand trial or not criminally responsible on account of mental disorder (NCR-MD), fall under the jurisdiction of the B.C. Review Board, which makes decisions as to the disposition of these patients. The board can order the person detained in custody in the institute, or released on conditions into the community.

Services are also provided on an out-patient basis through community services clinics in Vancouver, Victoria, Nanaimo, Prince George, Kamloops and Surrey. These clinics are responsible for the supervision and monitoring of persons found NCR-MD or unfit to stand trial who have been granted a conditional discharge by the review board.

The **Adult Mental Health Division** provides funding for and monitors the performance of mental health services in British Columbia. The division's mandate is to support health authorities, governmen' partners and provincial mental health agencies to reduce the impact of serious mental illness on individuals, families, and their community. This is achieved through the development of policies and funding for services that mitigate individuals' disabilities and support their recovery.

The January 1998 release of the Mental Health Plan marked a critical turning point in the planning and delivery of mental health services in British Columbia. The plan was developed based on a provincial consultation and recent literature on best practices in mental health reform. The goal of the plan is to develop responsive, respectful, and effective treatment and support for people with serious mental illness. The plan sets out ministry commitments to work with health authorities and other partners to:

- address the needs of adults with the most disabling functional impairment due to serious mental illness;
- promote early intervention and treatment strategies;
- promote best practices in mental health care so that programs and services are developed to produce optimal health outcomes for people with mental illness;
- increase the access to services for individuals with multiple problems, who historically have been poorly served (e.g. people with both mental illness and substance abuse issues);
- restructure support services to better respond to individuals' complex needs through outreach, assertive case management and appropriate medical care without hospitalization, where this is consistent with quality care;

- improve community support to low risk mentally disordered offenders and reduce the number of people with mental illness who come into conflict with the law;
- improve policy coordination with other ministries to better address income security, housing, training, employment, and other social supports.

MEDICAL SERVICES PLAN

The Medical Services Plan (MSP) is the mandatory medical insurance plan for residents of the province. It provides reimbursement for all medically required services and diagnostic facilities on a fee-for-service basis according to the schedule of fees approved by the Medical Services Commission. The plan also provides funding under alternative payment arrangements to physicians working on contract, salaried or sessional arrangements. In addition, the MSP provides incentives to physicians in rural areas and travel assistance to visiting specialists, pays for disability insurance and educational grants, subsidizes Canadian Medical Protective Association premiums, and provides a Contributory Professional Retirement Savings Plan for physicians.

The **Medical Services Commission** and the Medical Services Plan both operate under the authority of the *Medicare Protection Act*. This nine-member commission is made up of three representatives each from the British Columbia Medical Association (BCMA), the government and the public. The aim of the Medical Services Commission is twofold: to ensure reasonable access to quality medical, health and diagnostic services provided under the Medical Services Plan, and to develop more effective and cost-efficient methods of managing those services.

The **Strategic Planning and Development Division** is responsible for: MSP informational, economic and budgetary analysis and development; negotiations support; utilization management; alternative payment arrangements policy and administration; the northern and rural program; and public and professional education.

The **Supplementary Benefits Program** provides coverage for the most comprehensive range of supplementary health care services available in Canada, including the services of chiropractors, dental surgeons, massage therapists, naturopaths, optometrists, physical therapists and podiatrists. With the exception of dental surgery, the province provides funding for these services without cost sharing by the federal government.

THE SUPPLEMENTARY BENEFITS PROGRAM PROVIDES COVERAGE FOR THE MOST COMPREHENSIVE RANGE OF SUPPLEMENTARY HEALTH CARE SERVICES AVAILABLE IN CANADA

The primary function of the Medical Services Plan **Operations Division** is to administer the province's medical insurance plan by registering beneficiaries, billing premiums, and paying for services provided to people covered by MSP. This includes providing a program of premium assistance for British Columbians with low incomes. Staff also monitor practitioners' patterns of practice, investigate any misuses of MSP, and participate in practitioner fee negotiations.

CORPORATE PROGRAMS

Corporate Programs provides the ministry's central financial and administration management. Its primary function is to provide program areas with expertise and leadership in the areas of financial and management services, human resources, information and privacy, and legislation and professional regulation. In addition, Corporate Programs represents the ministry in its dealings with central agencies of government, such as the Treasury Board, the Public Service Employee Relations Commission, the Office of the Comptroller General, the Purchasing Commission and British Columbia Buildings Corporation.

The Finance and Management Services Division is responsible for developing, implementing and operating the ministry's fiscal management and control systems, and for providing general management support to program areas throughout the ministry. The division also provides financial and administrative services to support program delivery within the ministry.

The Human Resources Division provides advice and direction on all human resource matters within the ministry including recruitment, selection and placement of staff, labour relations issues, compensation, organization and classification, human resource planning, employment equity, occupational safety and health, staff development and training, and organizational development.

The Information and Privacy Branch is responsible within the ministry for the government's legislative commitment to make public bodies more accountable to the public and to protect personal privacy, as specified by the *Freedom of Information and Protection of Privacy Act* (*FOIPP Act*). Key functions of the branch include: assisting members of the general public to get access to ministry records while ensuring confidentiality of personal information; providing policy advice to program areas within the ministry on the protection of personal health information; and delivering training workshops and providing consultation to ministry staff, health authorities and health-related organizations in interpreting the *FOIPP Act*.

The **Legislation and Professional Regulation Division** is responsible for ensuring that the ministry's legislative requirements are met. This includes the development of new legislation, the amendment of existing legislation, and the preparation of regulations and orders-in-council. The division also oversees the regulation of health professions and works with 21 separate colleges on various governance issues. In addition, the division supports the work of the Health Professions Council and provides administrative support to Review Panels under the *Mental Health Act* and to appeal boards under other Acts.

PHARMACARE, PLANNING AND SPECIAL PROJECTS

Pharmacare, Planning and Special Projects is responsible for strategic planning, policy development and co-ordination, and management of the province's Pharmacare program.

The **Planning and Evaluation Division** provides economic and planning analysis, and program and operational evaluations. Specific areas of responsibility include health human resources planning, health service planning and strategic planning.

The **Policy Development and Project Management Division** is responsible for the development, coordination and review of policy initiatives in consultation with other divisions and ministries, and relevant stakeholders. In addition, the division manages cross-ministry issues including child health, immigration and special projects that arise from time to time.

The primary function of the **Women's Health Bureau** is to assist the ministry in developing a health care system that is sensitive to the unique needs of women. Staff work within government and liaise with community groups and health care providers to enhance understanding of women's health care issues. They also work with other ministries to address the broader social and economic needs of women. As well, the bureau acts as a secretariat to the Minister's Advisory Council on Women's Health.

The **Office for Seniors** is a focal point within the government for issues of concern to B.C. seniors. The office provides administrative support to the Minister Responsible for Seniors, provides administrative and research support to the Seniors' Advisory Council, monitors and collaborates on policy and program development across government, and provides information to the public regarding benefits for seniors. An important function of the Office for Seniors is to promote positive attitudes about aging and the elderly.

THE OFFICE FOR SENIORS IS A FOCAL POINT WITHIN THE GOVERNMENT FOR ISSUES OF CONCERN TO B.C. SENIORS.

The **Intergovernmental Relations** division provides services to assist the ministry in fulfilling its mandate by coordinating specific activities within the ministry, between ministries, and in its relationship with other governments. This includes policy, planning and support in relation to federal, provincial and territorial meetings of ministers and deputy ministers of health. The division provides project management, research analysis and advice on a broad range of intergovernmental issues. The division is also responsible for multiculturalism initiatives and reporting within the ministry. A key service of the division is events coordination for major meetings and conferences, including teleconferencing.

Through the **Pharmacare Program**, the provincial government assists B.C. residents with the cost of prescription medication, permanent prosthetic appliances, designated children's orthotic devices, home oxygen and certain other medical supplies. The program administers benefits through nine different plans. The largest plans are those for seniors, income assistance recipients and the general public. Pharmacare encourages appropriate utilization of prescription drugs, provides advice to government on federal initiatives related to the regulation of prescription medication and the pricing of pharmaceuticals, and works with professional colleges to encourage appropriate use of prescription medication.

INFORMATION MANAGEMENT GROUP

Under the direction of the Chief Information Officer, the Information Management Group is responsible for province-wide information management strategies, policies, standards and technology initiatives. This includes developing and implementing a strategic plan for information management, developing and ensuring compliance with information management polices and standards, maintaining technology support for the Medical Services Plan, Pharmacare and the continuing care system, and managing major strategic projects such as Health Net/BC and the re-engineering of health registration.

The **Planning and Information Resources Division** is the policy, standards and planning arm for information management. This division also provides general services such as corporate data administration, data security and library and records management, as well as information and analysis services to ministry programs.

The **Technology Management Division** provides technology solutions and services to meet the ministry's operating needs. The division manages the design, development and maintenance of all systems applications and network services, and supports staff use of these systems.

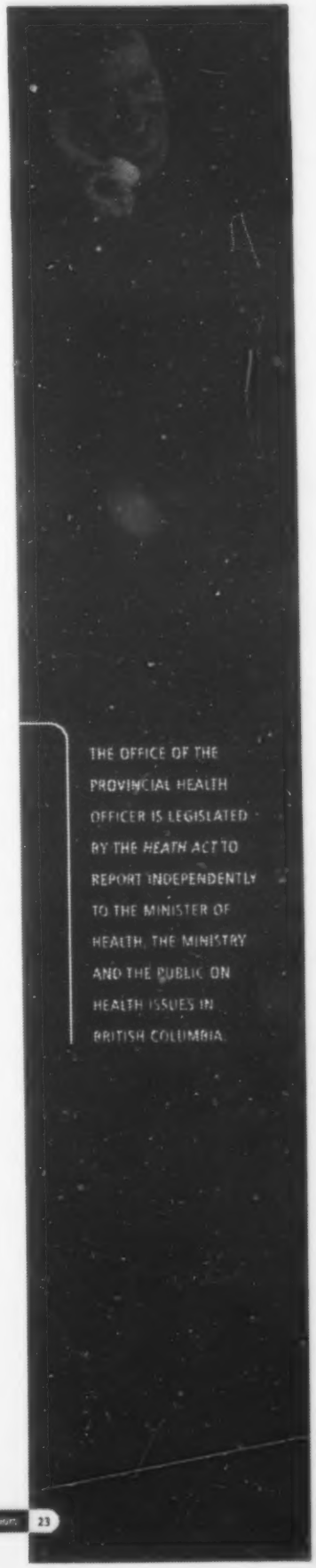
The **Vital Statistics Agency** is responsible for the registration and certification of all vital events in the province under the authority of the *Vital Statistics Act*, *Marriage Act*, and *Name Act*. The agency also maintains the Wills Registry and Health Status Registry under sections of the *Wills Act* and *Health Act*. In addition, Vital Statistics publishes a wide range of birth-related and mortality indicators in its annual report, quarterly digest, and other publications. As a special operating agency since 1996, the activities and achievements of the agency are outlined in its annual *Financial and Performance Report*.

COMMUNICATIONS

The **Communications Branch** is responsible for overall planning, implementation and evaluation of the ministry's communications activities. Services provided by the branch include issues management, communications project planning and management, media and public relations, advertising, and the development and execution of a wide range of health education and prevention initiatives.

OFFICE OF THE PROVINCIAL HEALTH OFFICER

The **Office of the Provincial Health Officer** is legislated by the *Heath Act* to report independently to the Minister of Health, the ministry and the public on health issues in British Columbia. The functions of this office include advising on health issues, producing an annual report on the health of the population and speaking out on public health issues, reporting on progress toward the government's health goals, assisting the ministry's major divisions with issues management and program and policy development, working with the B.C. Centre for Disease Control and the provincial Medical Health Officers to fulfill the legislated health protection and disease control mandate, chairing the Minister's Communicable Disease Policy Committee and serving as a member of the Federal/Provincial/Territorial Advisory Committee on Population Health.



THE OFFICE OF THE PROVINCIAL HEALTH OFFICER IS LEGISLATED BY THE *HEATH ACT* TO REPORT INDEPENDENTLY TO THE MINISTER OF HEALTH, THE MINISTRY AND THE PUBLIC ON HEALTH ISSUES IN BRITISH COLUMBIA.

Why Measure Performance?

There are several reasons why this annual report includes a diverse selection of performance measures:

- Because people care – British Columbians want to make sure health services will be there when they, or someone they care about, needs them. Performance measurement is one way to keep track of how these services are working.
- Because it helps us learn – When we measure performance across the province, it's possible to learn from the experience of those who are achieving particular success. Performance measurement is one way we can make sure good ideas get shared.
- Because it's essential to strategic planning – Strategic planning is all about using resources in ways that generate the best possible results for every dollar spent. Performance measurement gives us a way to tell whether particular initiatives are working, and to adjust if there are better ways to achieve our province's health goals.

How Do We Measure Performance?

It isn't always easy, mainly because there are so many different factors that contribute to health outcomes. However, the performance of our health system can be measured by the extent to which it achieves certain objectives. First and foremost, it must improve the health of British Columbians by preventing illness and premature death, relieving pain and suffering, and improving people's quality of life.

This is the first Ministry of Health annual report in which the ministry has undertaken to provide extensive information on the performance of our health system. Tracking and reporting this kind of information is consistent with the ministry's increasingly strategic approach and its strong commitment to making sure British Columbians get the greatest possible health benefit out of every tax dollar devoted to health care.

BECAUSE PEOPLE CARE – BRITISH COLUMBIANS WANT TO MAKE SURE HEALTH SERVICES WILL BE THERE WHEN THEY, OR SOMEONE THEY CARE ABOUT, NEEDS THEM

PROVINCIAL HEALTH OFFICER'S REPORTS

SINCE 1992, THE PROVINCIAL HEALTH OFFICER HAS BEEN REQUIRED BY THE *HEALTH ACT* TO REPORT ANNUALLY TO BRITISH COLUMBIANS ON THEIR HEALTH STATUS AND ON THE NEED FOR POLICIES AND PROGRAMS THAT WILL IMPROVE THEIR HEALTH. SOME OF THE REPORTS PRODUCED TO DATE HAVE GIVEN A BROAD OVERVIEW OF HEALTH STATUS, WHILE OTHERS HAVE FOCUSED ON PARTICULAR TOPICS SUCH AS WOMEN'S HEALTH, CHILD HEALTH, INJECTION DRUG USE, AND IMMUNIZATION.

PROVINCIAL HEALTH OFFICER'S REPORTS ARE ONE MEANS OF REPORTING ON PROGRESS TOWARD THE PROVINCIAL HEALTH GOALS WHICH WERE ADOPTED BY THE PROVINCE IN 1992. COPIES OF THE PROVINCIAL HEALTH OFFICER'S REPORTS AND THE DOCUMENT, HEALTH GOALS FOR BRITISH COLUMBIA, ARE AVAILABLE FROM THE OFFICE OF THE PROVINCIAL HEALTH OFFICER.

Performance Measures for 1998/99

The following section presents a selection of performance measures designed to illustrate the state of our publicly funded health system in 1998/99. This kind of information will be reported on in future years, to allow comparisons over time. Ministry staff has worked to identify meaningful measures that give a sense of the ministry and our health system's performance. These will undoubtedly be revised and expanded upon in the future.

This section is divided into four key areas:

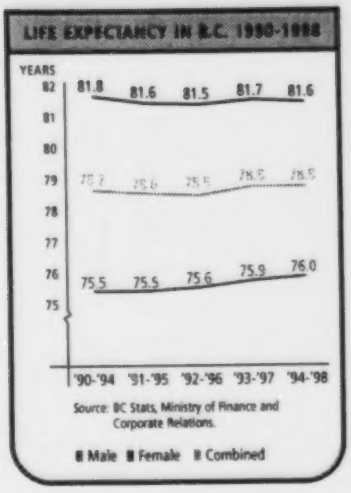
- Overall health – Measurement in areas that indicate the overall state of British Columbians' health in 1998/99.
- Accessibility – Measurement showing the extent to which British Columbians were able to get access to the services they needed.
- Quality – Measurement in areas that give a sense of the quality of services provided.
- Perspectives on health spending – Measurement of the amount spent on health care and the success of initiatives targeted at making sure health spending is cost-effective.

OVERALL HEALTH

The following indicators provide a snapshot of British Columbians' health in 1998/99. International research over the past 20 years has shown that the health of a population is influenced by a number of factors outside the health care system, such as level of income and education. Publications such as the *Provincial Health Officer's Annual Report* and the *Vital Statistics Annual Report* provide more detailed information on health status and the extent to which we are improving people's health, reducing sickness, and extending life expectancy.

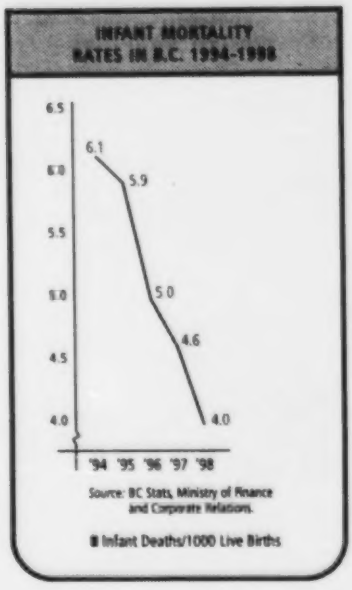
Life Expectancy

The infant mortality rate, an internationally accepted measure of population health, reached a record low of four per 1,000 population in 1998. On average, British Columbians are among the healthiest people in the world, and our level of health continues to improve, although there are clear disparities by income and other factors. Overall life expectancy has reached 76 years for men and 81.6 years for women.



Infant Mortality

For the province overall, fewer infants are dying in the first year of life, and early deaths due to heart disease, injuries, and other preventable causes are continuing to decline. However, differences in health status persist among groups and communities within the province.

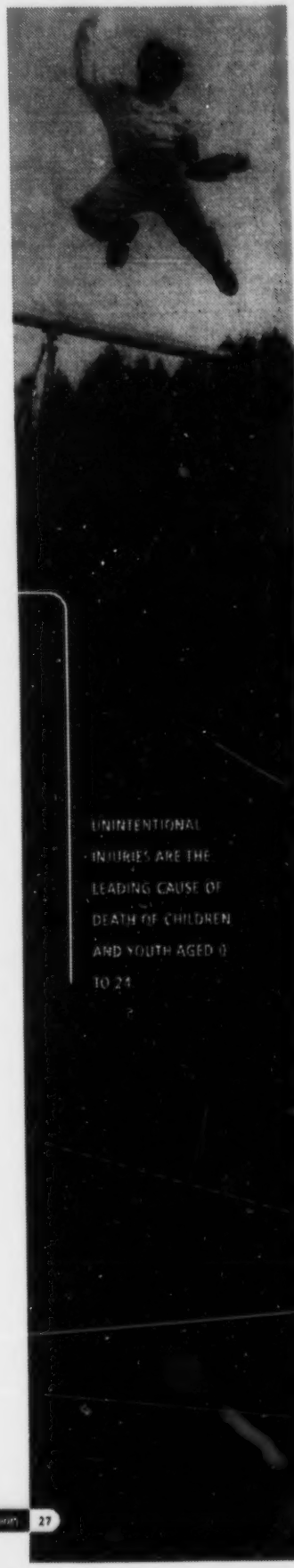


On average, infants who live in areas with lower incomes have up to twice the risk of dying before their first birthday, compared to infants in other areas of the province. This is reflected in higher rates of infant mortality for Aboriginal infants and infants born in northern areas and in certain parts of Vancouver. There is room for improvement and improvement must take place if all regions and population groups are to achieve the high level of health enjoyed by the healthiest groups.

Unintentional Injuries

Up to 90 per cent of injuries are preventable if proven prevention methods are fully implemented. In 1997, the Minister's Injury Prevention Advisory Committee developed injury prevention objectives and targets for children and youth age 0-24. This age group was the initial focus because unintentional injuries are the leading cause of death of children and youth aged 0 to 24.

If current trends continue, the year 2001 targets for reductions in injury hospitalizations and deaths will be met. Too many preventable injuries still occur, especially among children and youth, seniors, males, Aboriginal people, and people living in northern and rural parts of the province. The advisory committee and the Office of Injury Prevention is expected to turn its attention to seniors' injuries in the near future.

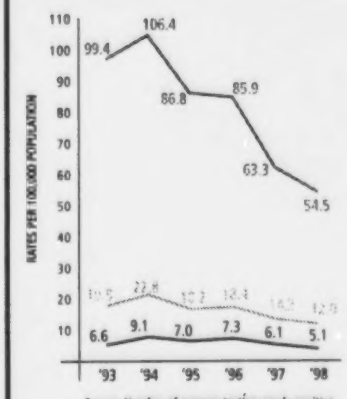


Incidence of HIV

Overall, the rate of new HIV infections has been declining, in part due to success in reducing transmission among men who have sex with men and harm reduction measures targeted at injection drug users. In 1995, injection drug users overtook men who have sex with men as the group with the highest number of positive HIV tests. Although the epidemic of HIV among injection drug users appears to have peaked, this group still accounts for about 40 per cent of the new HIV infections recorded. Aboriginal people make up approximately 15 per cent of those testing newly positive for HIV.

Regionally, Vancouver has by far the highest rates, although new positive cases occur in all areas of the province. HIV can be controlled through prevention programs and harm reduction strategies aimed at high-risk communities. Harm reduction strategies are practices that aim to decrease the negative personal, social and economic consequences of inappropriate activities such as drug use. These can be complemented by access to early testing, improved access to drug treatments, and actions to address the underlying factors that place people at increased risk of HIV infection.

PERSONS TESTING NEWLY POSITIVE FOR HIV BY HEALTH JURISDICTION, RATES PER 100,000 POPULATION B.C. 1993-1998



Source: Number of persons testing newly positive from STD/AIDS Control, BC Centre for Disease Control Society, HIV/AIDS Update Year End 1998. Table 2.13, pp. 26-27 Population estimates from BC Stats.

■ Vancouver ■ Rest of BC ■ BC Total

Food and Waterborne Diseases

Intestinal diseases such as salmonellosis, giardiasis (beaver fever), and E. coli are usually caused by consuming contaminated food or water. The extent of these illnesses is not known precisely, as most cases are not recognized or reported, and the source of the infection is not always known.

Based on the data we have, we know that British Columbians experience food and waterborne illnesses which they contract within the province or while travelling. Food and waterborne infections can be prevented through water treatment, watershed management, and promotion of safe food handling and storage practices. Hand washing is a simple but effective way to prevent the spread of intestinal diseases.

Tobacco Use

Tobacco use is the single most important preventable cause of illness and death in industrial countries. More than one in five British Columbians is a smoker, and about twenty B.C. children start smoking every day. Across the province, adult smoking rates range from 17 per cent (North Shore) to 29 per cent (North West and Peace Liard). During 1998/99, British Columbia greatly expanded its tobacco reduction efforts. Through continued, comprehensive efforts, we can dramatically reduce tobacco use and the illnesses it causes.

Exposure to Second-Hand Smoke

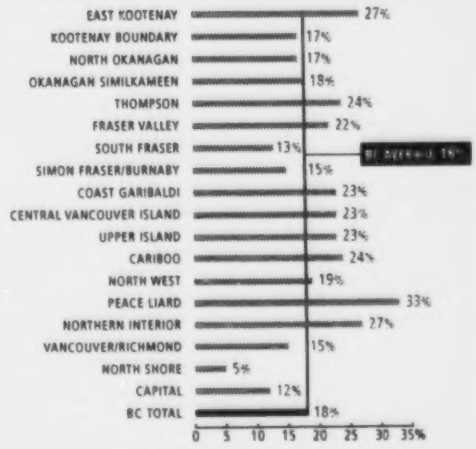
Second-hand smoke exposure has a significant impact on people's health, whether at work, in public places, or in homes.

Second-hand smoke can be particularly harmful to children's lungs, with short-term and long-term health effects. Almost one-fifth (18 per cent) of households with children under age 11 have daily or nearly daily exposure to second-hand smoke in the home. In some areas of the province, the percentage of homes with second-hand smoke is as high as 33 per cent. Exposure to second-hand smoke can be reduced through continued efforts to make public places smoke-free and by encouraging people to maintain smoke-free homes.

The Worker's Compensation Board established a new regulation that prohibited workplace exposure to second-hand smoke. This regulation came into effect in April 1998 in most workplaces.

TOBACCO USE IS THE SINGLE MOST IMPORTANT PREVENTABLE CAUSE OF ILLNESS AND DEATH IN INDUSTRIAL COUNTRIES

EXPOSURE TO SECOND-HAND SMOKE HOUSEHOLDS WITH CHILDREN < AGE 11, B.C. 1997 (BY HEALTH AUTHORITY)



Source: Tobacco Use in B.C. 1997. Heart and Stroke Foundation of B.C. and Yukon. A survey conducted by the Angus Reid Group with a grant from the B.C. Ministry of Health. http:www.hlth.gov.bc.ca/tobacrs

ACCESSIBILITY

All British Columbians should receive health services that help them achieve the best possible health. Health services should be available when and where they are needed, in a manner that meets people's needs and expectations, and without financial barriers.

Accessibility is one of the fundamental principles of Canada's health services system. The federal government's *Canada Health Act* and the B.C. government's *Medicare Protection Act* both guarantee British Columbians ready access to physician and hospital services when they need them. Access to other health services has also been a priority of the B.C. government which has committed itself to addressing the three factors that define accessibility: geographic access, financial accessibility and waiting times.

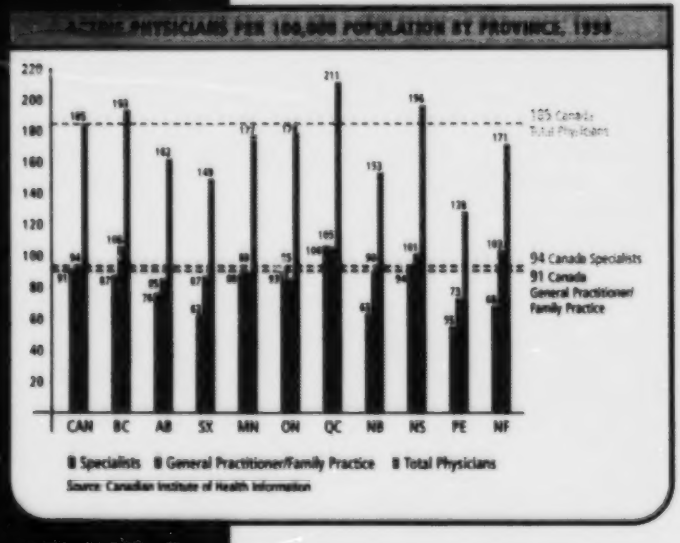
The following indicators have been selected to give an illustrative picture of health care accessibility in 1998/99 and a sense of overall trends. Accessibility to health services is closely linked to quality, so many of the procedures and services discussed in this section are also explored in the following section on quality.

The measures presented here provide a general idea of health service accessibility. The introduction to each section describes their limitations.

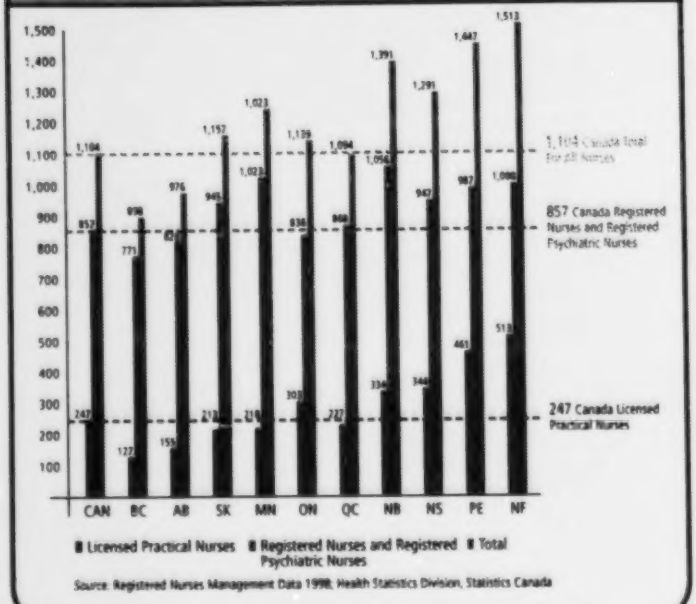
Human Resources

An adequate supply of qualified health professionals such as doctors and nurses is an essential pre-requisite for good access to care. While higher numbers might seem to indicate better accessibility to health services, this isn't always the case. There are two key limitations to using human resource numbers as indicator of accessibility:

- Province-wide information doesn't show variations from one part of the province to another. Generalizations based on province-wide numbers are of limited value.
- Larger numbers of a particular type of health professional do not necessarily lead to better health. Oversupply can be as much of a problem as undersupply, since it can create pressure to devote more health resources to an area that might contribute less to improving health than a similar expenditure in another area of the health system.



PRACTISING NURSES PER 100,000 POPULATION BY PROVINCE, 1998



Source: Registered Nurses Management Data 1998, Health Statistics Division, Statistics Canada

While views differ on what represents an "adequate" supply of any given profession, the figures presented here show that, overall, British Columbia is well supplied with physicians in comparison with the rest of Canada. In 1998, British Columbia had the third highest number of physicians for the size of our population of all Canadian provinces. Quebec and Nova Scotia had higher ratios of physicians to population. B.C. had Canada's highest ratio of general practitioners to population, and was slightly below the Canadian average in the ratio of specialists to population.

In contrast to British Columbia's relatively large number of physicians, the number of nurses per 100,000 population is lower in B.C. than in other provinces. It is difficult to draw direct comparisons between provinces because each has its own unique health care system and way of using nurses and other care providers. All provinces by early 1999 were beginning to feel the strain of an emerging nursing shortage and the need for a major recruitment effort.

ALL PROVINCES BY EARLY 1999 WERE BEGINNING TO FEEL THE STRAIN OF AN EMERGING NURSING SHORTAGE AND THE NEED FOR A MAJOR RECRUITMENT EFFORT

Services Delivered

This section reports the rates at which various health services were provided in 1998/99, in different regions and in comparison to previous years. For services of proven effectiveness such as immunization, cancer screening, blood pressure checks to detect hypertension, and counselling on smoking cessation, utilization rates - the proportion of the population who receive a given service – provide useful evidence of whether services are reaching those who need them. Low rates of utilization may indicate that some regions or groups are experiencing problems in getting access to these services.

This provides a very rough idea of how accessible these services were. However, with the exception of some diagnostic and preventative services such as immunization and pap smears, higher numbers of services delivered do not necessarily indicate success in improving the health of British Columbians.

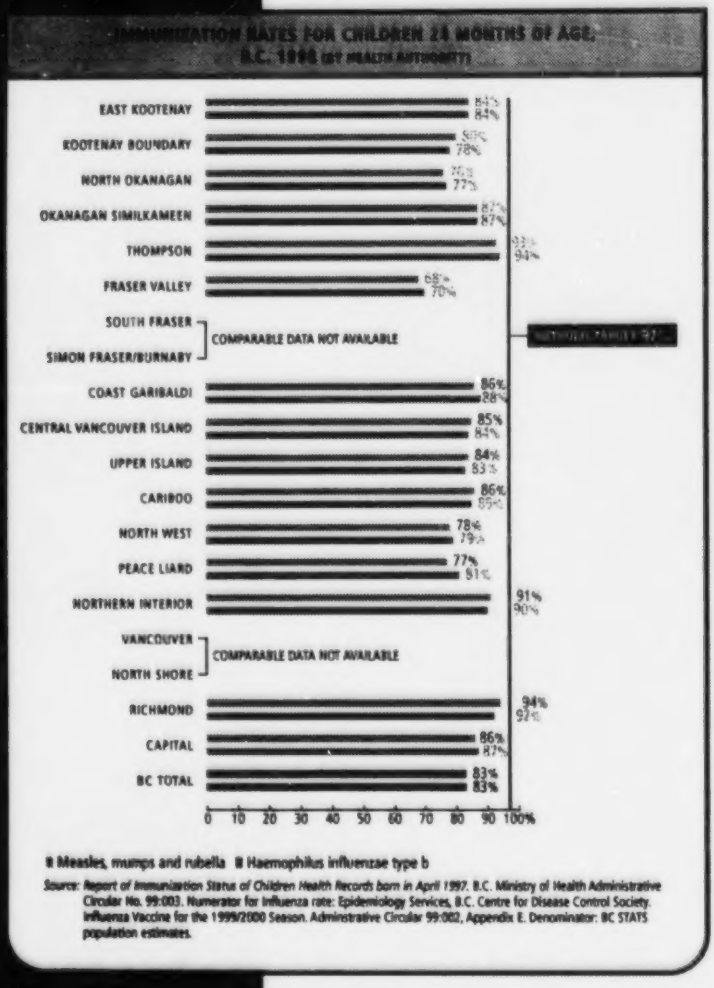
Preventive Services

Immunization Rates, Two-Year-Old Children

Immunization programs for children are among the most cost-effective of all health services. In British Columbia, all infants and preschool children have access to immunizations to protect them from eight serious diseases, including diphtheria, tetanus, polio and measles.

In 1998, more than 80 per cent of B.C. children had been immunized by their second birthday. In some regions and communities, almost all two-year-olds were fully immunized, with rates approaching the national target of 97 per cent. However, there are other areas of the province where the level of coverage needs to improve.

For some areas of the province, immunization statistics for two-year-olds are not available, in part due to difficulties in gathering statistics from doctors' offices. A province-wide computerized immunization registry, currently being introduced within public health, will be able to provide



Measles, mumps and rubella Haemophilus influenzae type b

Source: Report of Immunization Status of Children Health Records born in April 1997. B.C. Ministry of Health Administrative Circular No. 99:003. Numerator for Influenza rate: Epidemiology Services, B.C. Centre for Disease Control Society. Influenza Vaccine for the 1999/2000 Season. Administrative Circular 99:002, Appendix E. Denominator: BC STATS population estimates.

more complete information in the future. Based on the information we have available, B.C. is doing as well as or better than other parts of Canada in meeting immunization goals and targets.

Screening Services

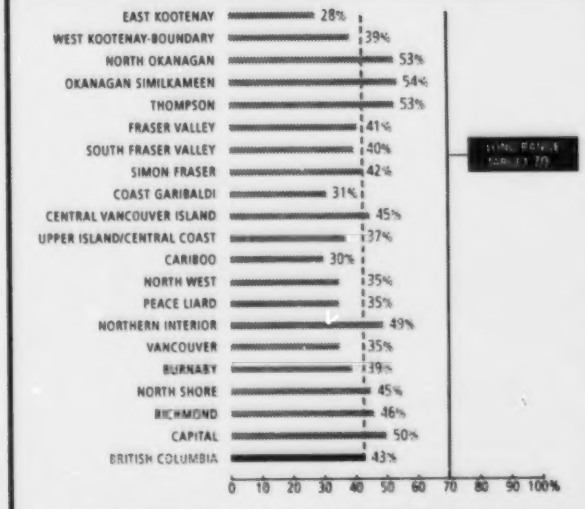
Screening Mammography

Screening mammography facilitates early detection and treatment of breast cancer. International studies have shown that screening mammography reduces death rates from breast cancer by 25 per cent or more if women between the ages of 50 and 69 are screened every two years.

The Screening Mammography Program of B.C. (SMPBC) began in 1988 and has expanded each year. SMPBC has extended the target age group to include women between 50 and 74, as SMPBC data show that women 70 to 79 may also benefit from screening. The goal of SMPBC is to screen at least 70 per cent of women between ages 50 and 74. SMPBC is gradually approaching this goal as more women attend screenings every year[1]. In 1996 and 1997, 36 per cent of B.C. women in this age group were screened by the SMPBC. In 1997 and 1998, this increased to 43 per cent.

[1] *Some women receive screens performed at centres that are not affiliated with SMPBC, so are not included in these data. These women may add another ten percent to the percentage of women receiving screening mammography.*

SCREENING MAMMOGRAPHY PARTICIPATION BY HEALTH REGION FOR WOMEN AGED 50-74 1996/97 AND 1997/98



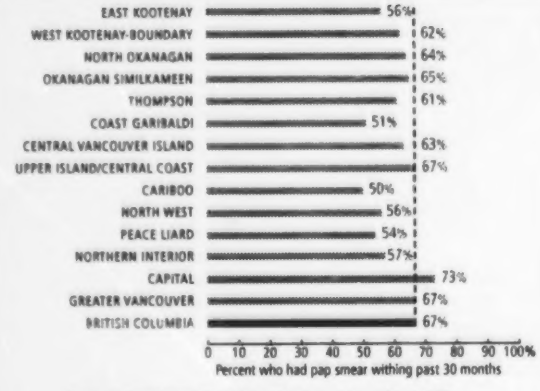
Source: 1998/99 Annual Report, Screening Mammography Program of BC.

OVER THE LAST 30 YEARS, THE INCIDENCE OF INVASIVE CANCER OF THE CERVIX IN B.C. HAS BEEN REDUCED BY 85 PER CENT

Pap Smears

A pap smear is a sample of cells taken from the cervix of a woman's uterus. The sample is microscopically examined to identify cancerous and pre-cancerous changes. Since the 1960s, B.C. has been a pioneer in the implementation of a widespread pap smear program. A central laboratory at the B.C. Cancer Agency receives, reviews and reports all pap smears performed in the province. This coordinated pap smear program allows for a significant reduction in the incidence of cervical cancer through identification and treatment of pre-cancerous conditions. Over the past 30 years, the incidence of invasive cancer of the cervix in B.C. has been reduced by 85 per cent. International evidence-based research supports the screening of sexually active women between the ages of 20 and 69 at least every three years. In the 30 months July 1996 to December 1998, the participation rate among B.C. women was 67 per cent. The literature shows that participation rates vary by level of income and education. The goal of the program is to ensure that all women in the target age group receive regular pap smears.

PAP SMEAR PARTICIPATION FOR B.C. WOMEN AGED 20-69 BY HEALTH REGION JULY 1996 TO DECEMBER 1998



Source: BC Cancer Agency (Cervical Screening Program Annual Report 1999)

Note: Greater Vancouver includes: Vancouver/Richmond, North Shore, Simon Fraser and South Fraser

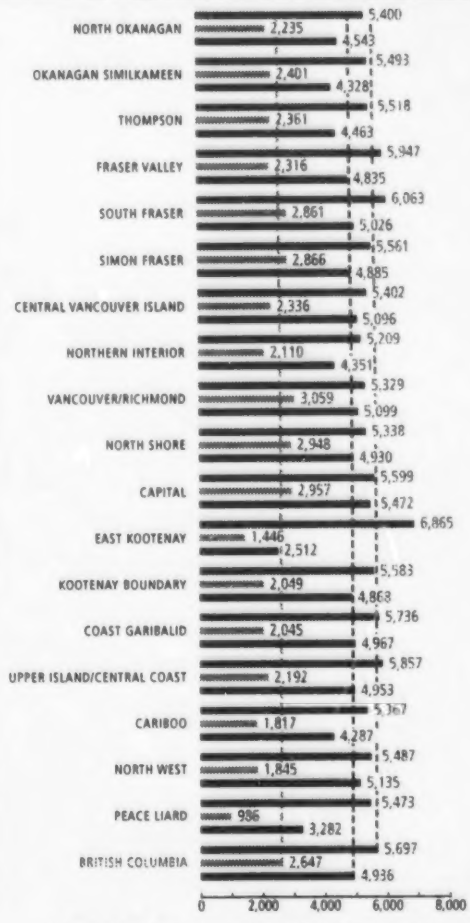
Physician Services

Many British Columbians consider the use of medical and hospital services to be a key indicator of our health system's success. However, more use of these services does not necessarily translate to better health, and in some cases doesn't even mean that they are more accessible. A healthier population does not necessarily use these services more than a less healthy population.

Utilization of medical services is relatively consistent across the province[2]. The main variation between regions is in the proportion of services provided by general practitioners as compared to the proportion provided by specialists. As a general rule, rural areas receive a higher proportion of care from general practitioners than do urban communities.

[2] *The utilization of services in the regions that border on Alberta – East Kootenays and Peace-Liard – are artificially low. This is because some residents in these areas use physicians located in Alberta, and that use is not recorded by the B.C. health system. In addition, the figures presented here do not include services paid for through the Medical Services Plan Alternative Payments program. As a result, figures are understated for some regions.*

PHYSICIAN SERVICES PER 1,000 POPULATION, BY HEALTH AUTHORITY, B.C. 1998/99*



Source: Discharge Abstract Database

*Includes fee for service data only.

The total number of urgent and emergency surgeries performed in B.C. remained relatively stable over the last five years despite an increasing and aging population. Some of this may be attributed to alternative forms of therapy replacing surgery, such as treating some conditions with drugs or new non-invasive techniques rather than performing surgery.

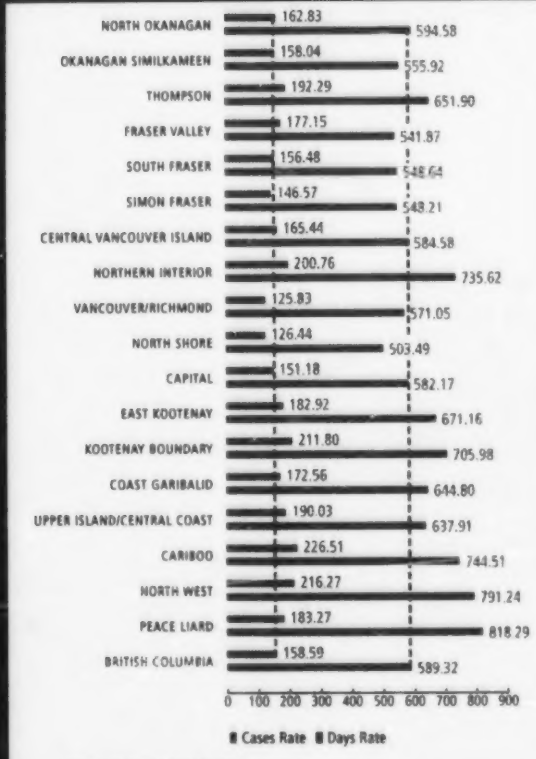
Over the last two years, the total number of surgical procedures carried out in B.C. decreased by approximately 1.5 percent and 2.6 percent respectively.

Rates of hospital use have fallen over the past five years, both in terms of cases and days per thousand population. The drop in days per thousand population continues a trend that has been underway for 30 years. Province-wide, the rate of acute, rehabilitation and surgical day care utilization has declined steadily, from 178.89 cases per thousand population in 1994/95 to 169.33 in 1996/97 and 158.59 in 1998/99.

Since the population of the province is increasing, the actual utilization of hospitals has dropped less than the rate decline seems to indicate.

The decrease in cases is a newer trend, probably reflecting better assessment of the need for admission, and the influence of various measures intended to keep people at home if at all possible. It also reflects the fact that more services can now be provided on an out-patient basis.

HOSPITAL DISCHARGE RATES IN B.C., 1998/99
(INCLUDES DISCHARGES FROM ACUTE CARE, REHABILITATION CARE AND SURGICAL DAYCARE)


NORTH OKANAGAN 162.83 594.58
OKANAGAN SIMILKAMEEN 158.04 555.92
THOMPSON 192.29 651.90
FRASER VALLEY 177.15 541.87
SOUTH FRASER 156.48 548.64
SIMON FRASER 146.57 548.21
CENTRAL VANCOUVER ISLAND 165.44 584.58
NORTHERN INTERIOR 200.76 735.62
VANCOUVER/RICHMOND 125.83 571.05
NORTH SHORE 126.44 503.49
CAPITAL 151.18 582.17
EAST KOOTENAY 182.92 671.16
KOOTENAY BOUNDARY 211.80 705.98
COAST GARIBALID 172.56 644.80
UPPER ISLAND/CENTRAL COAST 190.03 637.91
CARIBOO 226.51 744.51
NORTH WEST 216.27 791.24
PEACE LIARD 183.27 818.29
BRITISH COLUMBIA 158.59 589.32
0 100 200 300 400 500 600 700 800 900
Cases Rate
Days Rate

Source: Discharge Abstract Database

Note: Rates are per 1,000 population and are standardized using the indirect method and 19 age groups. Residents of B.C. treated out of province are included. Non-BC residents are excluded. Newborns are excluded.

Variation in cases and days between the regions is marked. Rural areas have higher rates of cases and of days per thousand population. This may reflect poorer health status, more available hospital beds, and the difficulty of providing community care in some remote areas.

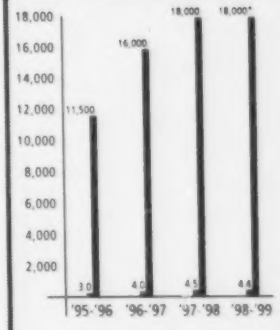
Organ Transplants

The number of organ transplants that take place in British Columbia each year depends on the availability of donated organs. Improved safety measures in B.C. have reduced the number of premature deaths and limited the supply of donated organs. As a result, there has been a strong reliance on living organ donors for kidney transplants. Mandatory referral legislation is being developed to help replicate the improved organ donation experience of some other jurisdictions, notably Pennsylvania.

CT and MRI Technology

Computerized Tomography (CT) and Magnetic Resonance Imaging (MRI) are sophisticated radiological techniques. CT scanning uses x-ray technology whereas MRI scanning uses electromagnetic fields. Both involve multiple images being taken and assembled by a computer to produce three-dimensional images. These imaging techniques are useful for investigation of many medical conditions and, as the technologies are very different, each is useful for specific situations or conditions. The machines are large, complex and expensive to purchase and to operate.

MRI SCANS FUNDED IN B.C., 1995/96 – 1998/99



Number of scans funded

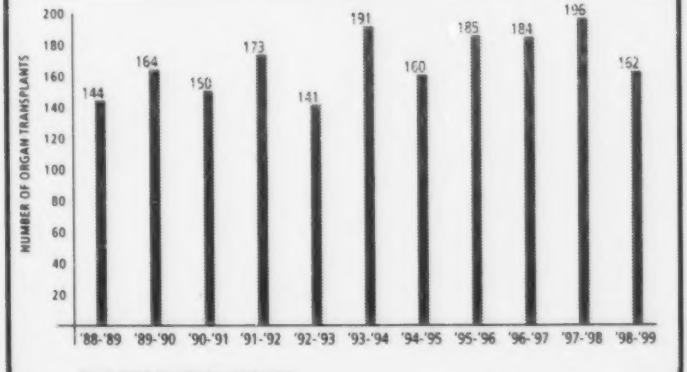
Number of scans funded per 1,000,000 population

Source: Data maintained by regional programs.

Note: The MRI data report only the number of scans funded by the Ministry of Health.

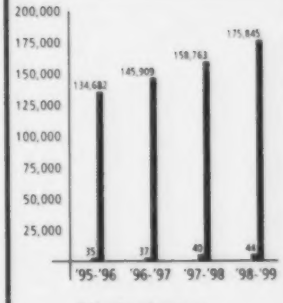
*In February 1999, funding for an additional 10,000 MRI scans was added, for a total of 28,000 MRI scans/year. Some MRI sites were able to increase the number of scans available in 1998/99. Other sites required time to train technicians and did not begin delivering additional scans until 1999/2000.

ORGAN TRANSPLANTS IN B.C., 1988/89 – 1998/99



Source: British Columbia Transplant Society

CT SCANS PERFORMED IN B.C., 1995/96 – 1998/99



Number of scans per 1,000 population

Number of scans performed

Source: Data are obtained through annual survey of 28 CT sites.

PHARMACARE EXPENDITURES AND NUMBER OF BENEFICIARIES BY PLAN 1997/98 – 1998/99

	1997/98		1998/99	
	BENEFICIARIES[2,3,4]	EXPENDITURE[1]	BENEFICIARIES[2,3,4]	EXPENDITURE[1]
PLAN A	408,937	$226,382,865	419,792	$248,443,480
PLAN B	24,856	$26,468,914	24,869	$27,671,121
PLAN C	241,027	$94,720,971	225,127	$104,051,470
PLAN D	250	$612,421	255	$644,212
PLAN E	201,164	$70,987,266	161,080	$67,401,595
PLAN F	1,805	$2,440,316	1,783	$2,565,690
PLAN G	7,078	$4,099,389	8,312	$5,594,394
TOTAL[4], PLANS A TO G	**868,662**	**$425,712,142**	**825,344**	**$456,371,962**
HOME OXYGEN PROGRAM	6,768	$14,361,525	7,190	$14,383,983
BC CENTRE FOR EXCELLENCE[5]	3,084	$22,531,622	3,262	$26,569,271
TOTAL FOR ALL PLANS		**$462,605,289**		**$497,325,216**

Source Notes:
1. The 1998/99 figures for expenditure are taken from the Ministry of Health Financial Management Report dated May 5th, 1999; the 1997/98 figures for expenditure are taken from the same report date May 11, 1998.
2. The beneficiary counts for plans A through G are taken from the Pharmacare Fiscal Year-To-Date, by Plan Report. The beneficiary counts for the Home Oxygen Program are taken from the Home Oxygen Invoice Totals Report.
3. The number of beneficiaries includes only those individuals with a Pharmacare paid claim in the fiscal year reported. The number of Plan C beneficiaries was lower in 1998/1999 reflecting a decrease in the number of social assistance receipts. The Plan E beneficiaries reduction reflects the increase in the Plan E deductible for 98/99.
4. The number of beneficiaries are not additive across plans as an individual may have received a benefit under more than one plan during the fiscal year. The total number of beneficiaries reported here reflects the distinct number of beneficiaries with a Pharmacare paid claim in the fiscal year across all plans.

Pharmacare Beneficiaries and Expenditures, By Plan 1997/98 and 1998/99

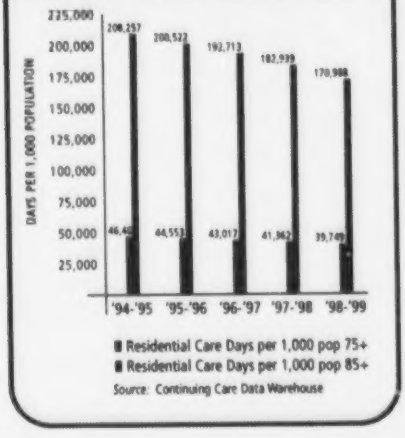
Pharmacare is the provincial drug program that helps British Columbia residents pay for eligible prescription drugs and designated medical supplies. Pharmacare benefits are provided by nine-different plans which target: seniors (Plan A); residents of long-term care facilities (Plan B); persons receiving medical benefits from the Ministry of Social Development and Economic Security (Plan C); cystic fibrosis patients (Plan D); medically-dependent children (Plan F); in-home patients requiring oxygen (Home Oxygen Program); patients receiving treatment for HIV/AIDS (BC Centre for Excellence), and all other residents of British Columbia (Plan E).

The chart above shows Pharmacare fiscal year expenditures along with the number of beneficiaries under each plan. The expenditure amount includes payments for drug costs as well as compensation to pharmacists. The number of beneficiaries is the number of individuals who made a claim to Pharmacare that resulted in a Pharmacare payment on their behalf during the fiscal year.

Residential and Home Care

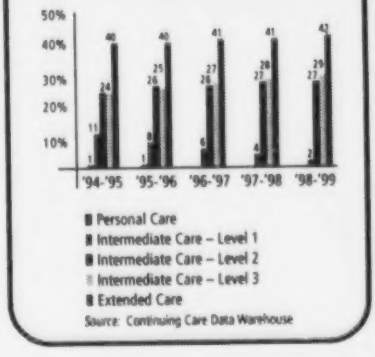
Over the past five years, British Columbia's population aged 75 and older has grown at more than twice the rate of growth in the general population. The number of people aged 75 and older has increased by 18 per cent and the number 85 and older has increased by 23 per cent. Although residential care utilization has remained nearly constant over the past five years (it has increased by one per cent), increased population has resulted in fewer days per capita. As a result, there has been a decrease in residential days per 1,000 population aged 75-plus and 85-plus by 14 per cent and 18 per cent respectively.

RESIDENTIAL CARE, DAYS PER 1,000 POPULATION AGE 75+ AND 85+, B.C. 1994/95 – 1998/99



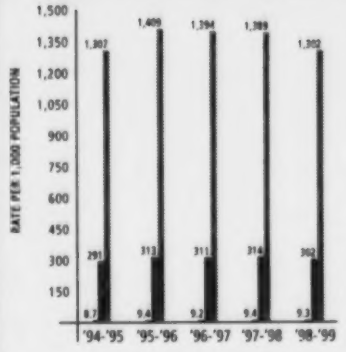
Over this time period, more clients with lighter care needs (Personal Care and Intermediate Care - Level 1) were being maintained at home as opposed to being admitted to a residential care bed. Over the past five years, 10 per cent fewer light care clients occupied residential care beds. The number of clients assessed as having the heaviest care needs (Intermediate Care – Level 3 and Extended Care) increased by seven per cent over the past five years.

RESIDENTIAL CARE DAYS BY LEVEL OF CARE, B.C. 1994/95 – 1998/99



Home Nursing Admissions have increased overall by 12,370 (23 per cent) over the past five years. Admissions per 1,000 population under age 75 have increased by 7 per cent. In the population aged 75 and older, admissions per 1,000 population have increased by 4 per cent.

HOME NURSING CARE ADMISSIONS PER 1,000 POPULATION BY AGES UNDER 75, 75+ AND 85+, 1994/95 – 1998/99

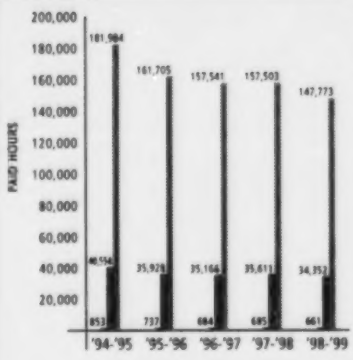


Source: Continuing Care Data Warehouse

Although home support paid hours have remained constant over the past five years, the increased population of older British Columbians has resulted in fewer paid hours per capita. There has been a decrease in paid hours per 1,000 population aged 75-plus and 85-plus by 15 per cent and 19 per cent respectively.

In addition, there has been a shift from lighter care to heavier care clients. Over the past five years, paid hours of home support for lighter care clients have decreased by 48 per cent and the number of paid hours for heavier care clients has increased by 37 per cent.

HOME SUPPORT SERVICES UTILIZATION PER 1,000 POPULATION AGES UNDER 75, 75+ AND 85+, BC 1994/95 – 1998/99



Source: Continuing Care Data Warehouse

Note: These figures do not include Community Support Independent Living clients (CSIL) – this combined with a change in policy, resulting in fewer home support hours to personal care clients, likely caused the decrease.

WAITING TIMES

Waiting times for surgery, treatment and diagnostic procedures have always been a major focus of public attention. It is essential that we keep waiting times short enough to protect health and minimize pain, worry and inconvenience. However, as with the other performance measures in this section, it is important to avoid making assumptions about waiting times. It is often forgotten that emergency cases do not go on waiting lists at all. Also, while there are good reasons why shorter waiting times are preferable to patients and their families, it is also true that waiting times for elective services do not necessarily lead to poorer health.

Some increases in waiting times can take place as a result of short term factors and can be addressed through targetted actions. However, to reduce waiting times over the long-term, the system's capacity must be increased, which is a more complex and long-term undertaking. In making decisions about waiting times, it is important to be clear on the actual health effects of waiting times and to compare the benefits of reducing waiting times with what can be gained by investing the same resource in other areas of the health system.

Surgical Procedures and Treatments

An elective case is one where the patient is able to wait without damage to their health. An emergency case is one in which the patient's health depends on immediate surgery. The waiting times presented in this report include only elective cases, as emergency cases go ahead without patients being placed on a waiting list.

A total of 380,971 surgical procedures were carried out in B.C. during 1998/99. Of these, 356,307 were elective and the remaining 24,664 were emergency.

Public attention is often focused on the number of cases waiting for a particular procedure. However, for a person who is waiting, it is usually far more important to know how long they will likely wait rather than how many people are ahead of them on the list. That is why waiting times are used in this and other Ministry of Health reporting.

IT IS ESSENTIAL THAT WE KEEP WAITING TIMES SHORT ENOUGH TO PROTECT HEALTH AND MINIMIZE PAIN, WORRY AND INCONVENIENCE.

WAITING TIMES FOR CERTAIN ELECTIVE SURGICAL PROCEDURES B.C., 1995/96 – 1998/99

	MEDIAN WAIT MAR '96	SURGERIES APR '95-MAR '96	MEDIAN WAIT MAR '97	SURGERIES APR '96-MAR '97	MEDIAN WAIT MAR '98	SURGERIES APR '97-MAR '98	MEDIAN WAIT MAR '99	SURGERIES APR '98-MAR '99
CARDIAC SURGERY	10 weeks	1,515	16 weeks	1,465	16 weeks	1,634	11 weeks	1,586
DENTAL SURGERY	4.3 weeks	4,867	4.5 weeks	5,424	4.4 weeks	5,402	5.1 weeks	5,064
EAR, NOSE & THROAT	4 weeks	14,127	4.4 weeks	14,828	4.1 weeks	14,997	5 weeks	13,168
GENERAL SURGERY	2.9 weeks	30,925	3 weeks	33,857	3 weeks	36,100	3.6 weeks	32,646
GYNAECOLOGY	2.4 weeks	30,809	2.4 weeks	29,686	2.4 weeks	30,188	3 weeks	27,456
NEUROSURGERY	2.4 weeks	3,732	2.4 weeks	3,985	2.7 weeks	4,009	3.1 weeks	3,478
OPHTHALMOLOGY	6.3 weeks	22,571	6.1 weeks	26,162	6.1 weeks	26,779	8.1 weeks	22,193
ORTHOPEDICS	6 weeks	23,257	5.9 weeks	25,892	5.4 weeks	27,329	7.3 weeks	25,423
PLASTIC SURGERY	5 weeks	7,987	5.4 weeks	8,258	6.5 weeks	8,344	7.6 weeks	7,776
UROLOGY	3.7 weeks	23,263	3.1 weeks	24,198	2.9 weeks	24,382	3.1 weeks	22,143
VASCULAR SURGERY	1.7 weeks	2,686	1.7 weeks	3,170	1.7 weeks	3,366	1.9 weeks	2,977

Source: Surgical Waitlist Registry

Note: These figures do not include certain procedures carried out in small facilities or certain minor elective procedures.

Median waits for all periods are based on procedures performed over the previous 6 months. The data includes booked surgeries for hospitals participating in the Registry. It does not include emergency surgeries since these are not booked.

As the charts indicate, the median waiting time[8] for surgery in B.C. remained relatively steady from the mid-1990s to 1998, even for high demand procedures such as hip and knee replacement surgery and cataract surgery. During this period the total number of surgeries performed increased.

During the 1998/99 fiscal year, the number of surgeries dipped and median wait times for elective procedures increased particularly for hip and knee replacement surgeries, in spite of increased funding for health care. A contributing factor to the increase in wait time was job action by physicians and nurses.

8 The median waiting time is the standard way of measuring waiting times. It is the point at which one half of patients have had their surgery and the other half are still waiting. For example, if a median waiting time is four weeks, that means half the patients have their surgery before four weeks, and half the patients will have their surgery after four weeks.

NON-EMERGENCY CARDIAC SURGERY WAIT TIMES B.C., 1995/96 – 1998/99

	MARCH 1995	SEPT1995	MARCH 1996	SEPT 1996	MARCH 1997	SEPT 1997	MARCH 1998	SEPT 1998	DEC 1998
Median wait (in weeks)	11	9	10	12	16	14	16	12	11

Source: BC Cardiac Registry

CATARACT SURGERY WAIT TIMES B.C., 1995/96 – 1998/99

	JULY 1995	DECEMBER 1995	JULY 1996	DECEMBER 1996	JULY 1997	DECEMBER 1997	JULY 1998	DECEMBER 1998
Patients waiting	5,036	5,876	6,679	6,147	6,754	6,925	6,938	7,175
Cases completed (previous 6 months)	7,886	8,193	10,423	10,271	10,969	10,053	10,658	8,691
Median wait	8.1	8.1	7.7	8.1	7.3	8.9	6.6	9.9

(in weeks, over previous 6 months)

Source: Surgical Waitlist Registry

HIP REPLACEMENT WAIT TIMES B.C., 1995/96 – 1998/99

	JULY 1995	DECEMBER 1995	JULY 1996	DECEMBER 1996	JULY 1997	DECEMBER 1997	JULY 1998	DECEMBER 1998
Patients waiting	619	731	696	781	851	912	1,060	1,305
Cases completed (previous 6 months)	942	961	1,111	998	1,191	998	1,158	813
Median wait	10.8	9.1	8.0	9.0	9.4	9.9	10.6	12.4

(in weeks, over previous 6 months)

Source: Surgical Waitlist Registry

KNEE REPLACEMENT WAIT TIMES B.C., 1995/96 – 1998/99

	JULY 1995	DECEMBER 1995	JULY 1996	DECEMBER 1996	JULY 1997	DECEMBER 1997	JULY 1998	DECEMBER 1998
Patients waiting	649	811	802	897	1,062	1,121	1,371	1,623
Cases completed (previous 6 months)	726	763	929	885	1,079	924	1,072	784
Median wait	14.9	12.9	11.6	12.0	11.3	12.9	13.0	16.7

(in weeks, over previous 6 months)

Source: Surgical Waitlist Registry

CORNEAL TRANSPLANTS WAIT TIMES, B.C. 1995 – 1998/99

	MEDIAN WAIT MAR '96	SURGERIES APR '95-MAR '96	MEDIAN WAIT MAR '97	SURGERIES APR '96-MAR '97	MEDIAN WAIT MAR '98	SURGERIES APR '97-MAR '98	MEDIAN WAIT MAR '99	SURGERIES APR '98-MAR '99
Corneal Surgery	11 months	581	9 months	537	6 months	487	5 months	503

Source: Eye Bank of BC

Information on Selected Procedures

The median wait time for cataract surgery was stable until mid-1998, after which the median wait time increased.

Waiting times for corneal transplants depend to a great extent on availability of corneal tissue. Despite a shortage of tissue supply, the Corneal Transplant Program has been able to reduce the waiting list and waiting time substantially over the past three years.

The December 1998 median wait time for hip and knee replacement surgery appears related to a decrease in the actual numbers of surgeries performed than in any of the seven previous reporting periods. Many factors can account for the wait time increase/surgery decrease in this reporting period: availability of staff, increases in emergency services, and availability of operating room time. Health authorities and the Ministry of Health routinely monitor wait times and, where necessary, intervene by providing funding to address wait time peaks, rescheduling operating room arrangements or taking other administrative measures to increase surgical throughput.

IN 1998, THE MINISTRY OF HEALTH ADDED AN EXTRA $8.5 MILLION TO PERFORM 450 MORE CARDIAC SURGERIES, INCREASED ANGIOPLASTY PROCEDURES AND OTHER IMPROVEMENTS TO CARDIAC CARE. AS A RESULT, THE DECEMBER 1998 MEDIAN WAIT TIME WAS THE SHORTEST IT HAD BEEN IN MORE THAN TWO YEARS.

Half of all heart surgery patients in B.C. receive their surgery on an emergency basis. For the other half of patients, surgically classified as non-emergency cases, B.C. has a well-developed cardiac registry that monitors wait lists, wait times, and treatments for cardiac disease.

The number of heart operations performed each year has grown proportionally faster than B.C.'s population. In 1998, the Ministry of Health added an extra $8.5 million to perform 450 more cardiac surgeries, increased angioplasty procedures and other improvements to cardiac care. As a result, the December 1998 median wait time was the shortest it had been in more than two years.

Waiting times for cancer radiation therapy increased slightly from 1997/98 to 1998/99. The ministry is improving access to radiotherapy services through the construction of a new and expanded cancer clinic in Victoria, the installation of a fifth radiotherapy machine in Surrey, and increased services in Kelowna.

Another element of cancer waiting times is the time a patient must wait to see an oncologist. In 1998/99 the median wait from referral to a medical oncologist was seven to nine days and for radiation oncologist 11 to 13 days.

Emergency

British Columbia Ambulance Service

Research has shown that patients with severe injury or illness such as major trauma or cardiac arrest benefit from reduced ambulance response times. The B.C. Ambulance Service (BCAS) adopted a method of response time reporting that shows the percentage of responses that meet or exceed the standard for each category of ambulance calls. The call categories are:

Alpha Call: those illnesses or injuries in which patient outcome will not be affected. The response time standard is 15 minutes or less.

Bravo Call: those medical emergencies where time may affect patient outcome. The response time standard is ten minutes or less.

Charlie Call: potentially life-threatening emergencies where time may affect patient outcome. The response time standard is ten minutes or less.

Delta Call: the most serious life-threatening emergencies where response time is of the essence. The response time standard is eight minutes or less.

The goal adopted by the BCAS is to meet the Delta response time standard of eight minutes or less, 90 per cent of the time in metropolitan/urban areas.

CANCER RADIATION THERAPY WAIT TIMES B.C., 1995/96 – 1998/99

	MEDIAN WAIT MAR '96	COURSES OF TREATMENT 1996	MEDIAN WAIT MAR '97*	COURSES OF TREATMENT 1997	MEDIAN WAIT MAR '98	COURSES OF TREATMENT 1998	MEDIAN WAIT MAR '99	COURSES OF TREATMENT 1999**
Radiation Therapy	N/A	7,877	1.1 weeks	8,334	1.4 weeks	8,670	1.6 weeks	9,616

Note: *Median Wait is based on courses of treatment performed over the previous 6 months.
**1999 Projected on the basis of the first six months

Source: BC Cancer Agency

The average ambulance response time to the most urgent Delta calls in Vancouver was 8.2 minutes. The average response time in other Lower Mainland locations was 9.5 minutes. This reflects the greater distances that must be traveled in suburban areas.

The BCAS recognizes the need to improve response times. A number of steps were taken during the fiscal year to improve response times:

- A quality improvement program was established to develop and produce response time reports and standards.
- A new system was introduced to make sure 9-1-1 calls are assessed consistently and put in the proper category.
- A plan was implemented to make sure ambulance resources are assigned in a consistent way.
- Dedicated patient transfer services were established in Vancouver and Victoria.
- The tracking of response times by location was introduced in the Vancouver area and will be introduced throughout the province.

QUALITY

British Columbians don't just expect health services to be accessible. They also expect them to be of high quality. The quality of health services depends on the skills of the providers, the facilities and equipment used and the organisation and administration of the services.

The meaning of the term 'quality' and how to measure it are matters of opinion. Quality means different things to different people. Some would measure quality by the perceptions of people who use the system. Others would use statistical measures of efficiency. And others would focus on the assessment of health outcomes.

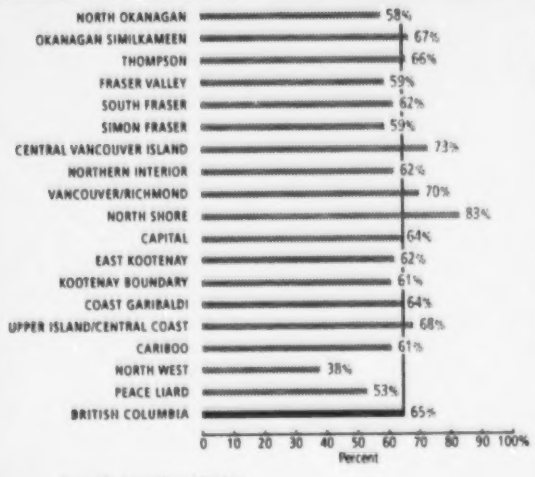
Many current indicators and measurements of quality have been used, and the Canadian Institute of Health Information (CIHI) has determined that no single measure of quality exists, and that the best approach is to use a variety of quality indicators.

The following indicators are relatively simple and are presented as examples of how we might measure the quality of our health system. The ministry is working to develop indicators that cross service lines, so that a comprehensive and more meaningful picture of service quality can be provided in the future.

Breast-Conserving Surgery

Breast cancer is the most common cause of death due to cancer in women. The treatment of breast cancer depends on how far it has spread. For localized cancer, it is now considered preferable to treat it through breast-conserving surgery rather than through complete mastectomy. Studies have shown that women who have breast-conserving surgery, followed by radiation therapy, have the same survival rates as those undergoing complete mastectomy. Since breast-conserving surgery is less traumatic, physically and psychologically, it is a desirable practice. Increased use of breast conserving surgery rather than mastectomy is considered an indicator of improved health care quality. In Canada, the rate of breast conserving surgery is reported by CIHI.

BREAST CONVERSING SURGERY AS PERCENT OF ALL FEMALE BREAST CANCER SURGERY, B.C. 1998/99 (BY HEALTH AUTHORITY)



Source: Discharge Abstract Database

The level of breast-conserving surgery as a proportion of all cases of breast cancer has changed little over the past five years – from 2.26 cases to 2.32 cases per 1,000 population. The rate of surgery as a percentage of breast cancer cases has increased from 66 to 70 per cent, and the rate of breast-conserving surgery has risen from 62 to 65 per cent.

Only a small part of the variation between B.C. regions is due to variations in the incidence of breast cancer, and there is little reason to believe that the severity of cases is very different between geographic regions. Variation in rates between geographic areas might be due to small numbers of cases, while variation in the larger regions is likely due to differences in clinical practice.

The absence of day care surgery data for B.C. patients treated in Alberta in 1997/98 and 1998/99 might make the rates and percentages for residents of the East Kootenay and Peace Liard slightly lower than is actually the case.

Immunization of Seniors

Influenza is a major cause of illness, hospitalization, and death among older persons and among people with certain medical conditions. Annual influenza immunization prevents influenza-like illness and lessens the severity of disease.

For pneumococcal immunization, a one-time dose provides life-long protection for most people. Publicly funded pneumococcal immunization for all people age 65 and older began in April 1998.

An estimated 58 per cent of British Columbians age 65 and older had an influenza shot during the 1998/99 flu season – far below the proposed target of 90 per cent.

Another important population group is residents of long-term care facilities. Because of their age, medical condition, and group living situation, this group is particularly vulnerable to influenza. For facility residents, vaccine uptake is commendable – 84 per cent received influenza vaccine in 1998/89. In several regions, rates have surpassed the national goal of 90 per cent, while many other regions are approaching this goal.

To protect health care workers – and to safeguard the vulnerable people they care for – it is vitally important that health staff be immunized. In 1998/99, the immunization rate for staff of care facilities was only 32 per cent, up from 28 per cent the previous year, but still far below the 90 per cent target.

Immunization coverage could be improved for all risk groups, especially people age 65 and older, people with chronic diseases in all age groups, and health care workers.

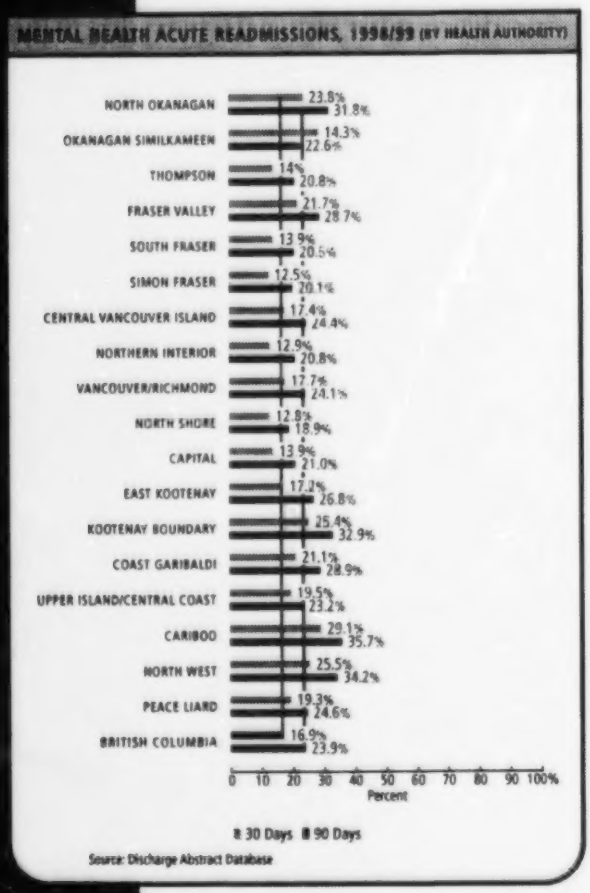
Mental Health Readmissions to Hospitals

Severe mental health disorders such as bipolar disorders and schizophrenia are the most common reasons for admission to hospital with a mental health related diagnosis. While admission may be necessary for acute treatment, most patients can be well maintained in the community with regular follow-up and supportive services. Therefore, lower rates of readmission to hospital soon after discharge are considered to be an indicator of improving health care quality.

The table at left shows the readmission percentages for patients discharged from hospital with a principal diagnosis of severe mental illness.

For the province as a whole, out of 12,855 discharges that occurred in 1998/99, 16.9 per cent were readmitted within 30 days, another 4.3 per cent within 60 days and an additional 2.7 per cent within three months. There is considerable variation between the regions, with over a third of patients being readmitted in three regions, and under one in six in one region. In all regions, the majority of readmissions occur within 30 days following discharge from hospital.

Regional breakdowns do not support a suggestion that there might be a trade-off relationship between community mental health services availability and hospital readmission.


MENTAL HEALTH ACUTE READMISSIONS, 1998/99 (BY HEALTH AUTHORITY)
NORTH OKANAGAN 23.8% 31.8%
OKANAGAN SIMILKAMEEN 14.3% 22.6%
THOMPSON 14% 20.8%
FRASER VALLEY 21.7% 28.7%
SOUTH FRASER 13.9% 20.5%
SIMON FRASER 12.5% 20.1%
CENTRAL VANCOUVER ISLAND 17.4% 24.4%
NORTHERN INTERIOR 12.9% 20.8%
VANCOUVER/RICHMOND 17.7% 24.1%
NORTH SHORE 12.8% 18.9%
CAPITAL 13.9% 21.0%
EAST KOOTENAY 17.2% 26.8%
KOOTENAY BOUNDARY 25.4% 32.9%
COAST GARIBALDI 21.1% 28.9%
UPPER ISLAND/CENTRAL COAST 19.5% 23.2%
CARIBOO 29.1% 35.7%
NORTH WEST 25.5% 34.2%
PEACE LIARD 19.3% 24.6%
BRITISH COLUMBIA 16.9% 23.9%
0 10 20 30 40 50 60 70 80 90 100%
Percent
30 Days 90 Days
Source: Discharge Abstract Database

Hip Replacement Surgery

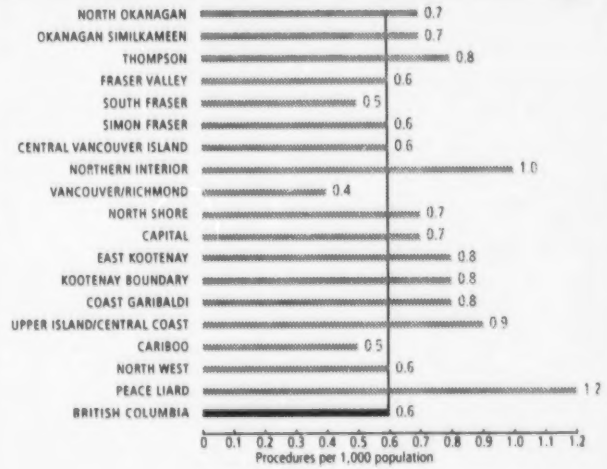
Hip joint replacement is a well-proven procedure that increases mobility for many patients with osteo-arthritis, trauma and congenital damage to their hip joints. The procedure requires the use of relatively expensive artificial joints and intensive rehabilitation. Additional funds have been directed at this and knee replacement surgery over the years.

Over the past seven years, the rate of hip replacement in B.C. has remained relatively stable at 0.6 to 0.7 cases per 1,000 population. The number of procedures carried out was fairly constant from 1995/96 through to 1997/98 at around 2,650, but in 1998/99 dropped by over 100 cases. This may reflect reduced activity and/or hospital resource allocation decisions. Lengths of stay per case have dropped steadily over the seven years, from 11.1 days in 1992/93 to 6.3 days in 1998/99.

As the table indicates, in 1998/99, regions varied from 0.4 cases per 1,000 population in Vancouver/ Richmond region and 0.5 cases per 1,000 population in the South Fraser Valley and Cariboo regions to 1.0 cases per 1000 in the Northern Interior and 1.2 per 1,000 population in the Peace-Liard region. This degree of variation has persisted through the years. Similar levels of variation are found in Ontario but are not statistically significant.

There is no obvious urban/rural difference in the rates of surgery, although residents of the Lower Mainland generally have a rate of surgery at or below the provincial average, whereas those living elsewhere have rates at or above the provincial rate.

HIP REPLACEMENT SURGERY RATE
(PROCEDURES PER 1,000 POPULATION), BC 1998/99 (BY HEALTH AUTHORITY)



Source: Discharge Abstract Database

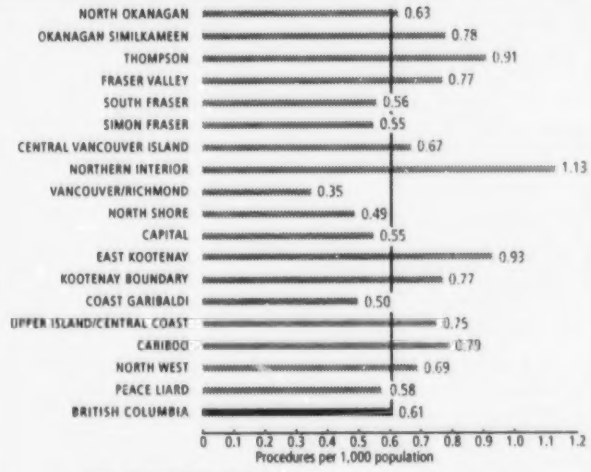
Note: Includes out of province cases.

Knee Joint Replacement Surgery

As with hip replacements, the rate of knee replacements has remained steady for the last four years, after a rise of over a third between 1992/93 and 1995/96. The number of cases for the past two years has been virtually the same, at just less than 2,500 per year. As with hips, lengths of hospital stay have been dropping steadily, from nearly seven days in 1992/93 to just over five days in 1998/99.

Inter-regional variation is larger than that found with hip replacement. The rates vary from 0.35 cases per 1,000 population in Vancouver Richmond to 1.13 cases per 1,000 in the Northern Interior. Again, only one of the more rural regions had a rate below the provincial average – Peace Liard – while major population centres in the Lower Mainland and Victoria had rates below the provincial average.

KNEE JOINT REPLACEMENT SURGERY RATE (PROCEDURES PER 1,000 POPULATION), B.C. 1998/99 (BY HEALTH AUTHORITY)



Source: Discharge Abstract Database

Note: Includes out of province cases.

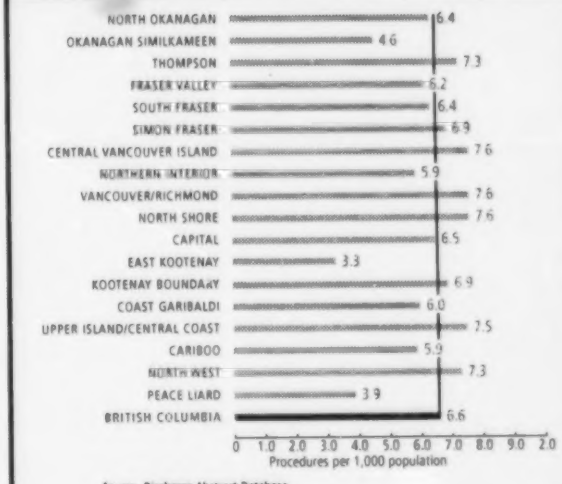
Cataract Surgery

Cataract surgery is the removal of a clouded lens from one or both eyes and the insertion of an artificial lens. This improves eyesight considerably. Clouding of the lens is a condition that becomes more common as people grow older. There is no known way to prevent most cases of this condition. As techniques have improved over the years, the procedure has moved from being performed as an inpatient procedure to being carried out on an outpatient basis. In 1998/99 only 1.1 per cent of these procedures were carried out as inpatient procedures.

The rate of cases per 1,000 population has risen steadily from 5.0 per 1,000 in 1992/93 to 6.6 per 1,000 in 1998/99. Variation between regions, not including East Kootenay and Peace Liard, is small – from 4.6 per 1,000 in the Okanagan Similkameen, to 7.6 cases per 1,000 in the North Shore region.

Lower rates in the East Kootenay and Peace-Liard regions can likely be explained by the fact that day care surgery carried out on B.C. residents in Alberta facilities is not included in these figures.

CATARACT SURGERY RATE
(PROCEDURES PER 1,000 POPULATION) 1998/99 (BY HEALTH AUTHORITY)



Source: Discharge Abstract Database

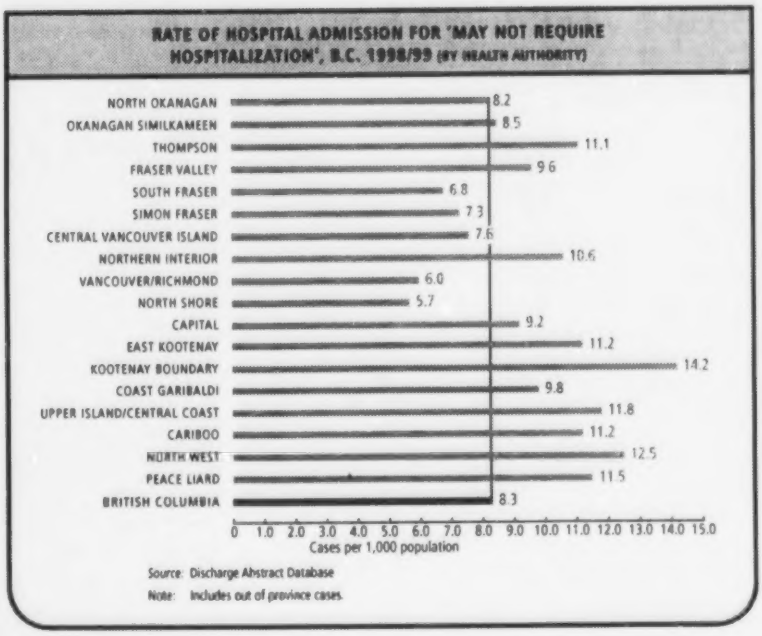
Note: Includes out of province cases.

Admission to Hospital for MNRH Conditions

By analyzing all the cases discharged from hospitals throughout Canada, the Canadian Institute for Health Information (CIHI) regularly identifies procedures that may require admission to hospital as an inpatient. A May Not Require Hospitalisation (MNRH) admission to hospital is a case where a patient is admitted to hospital even though the procedure usually does not require admittance. A lower rate of admission to hospital for MNRH conditions is considered to be an indicator of improving health care quality.

The data show a consistently dropping rate of MNRH cases per 1,000 population over the past five years. Days per 1,000 population for these cases have also dropped by over a third - i.e. the average length of stay has stayed the same. This would be consistent with continued efforts to avoid unnecessary hospitalization. In addition to dropping in absolute terms, MNRH cases have dropped as a percentage of all inpatient cases – from 11 per cent in 1994/95 to 8.5 per cent in 1998/99.

Variation between regions is relatively high, with a rate of 5.66 cases per 1,000 population in the North Shore region and 14.2 cases per 1,000 in the West Kootenay region.


RATE OF HOSPITAL ADMISSION FOR 'MAY NOT REQUIRE HOSPITALIZATION', B.C. 1998/99 (BY HEALTH AUTHORITY)
NORTH OKANAGAN 8.2
OKANAGAN SIMILKAMEEN 8.5
THOMPSON 11.1
FRASER VALLEY 9.6
SOUTH FRASER 6.8
SIMON FRASER 7.3
CENTRAL VANCOUVER ISLAND 7.6
NORTHERN INTERIOR 10.6
VANCOUVER/RICHMOND 6.0
NORTH SHORE 5.7
CAPITAL 9.2
EAST KOOTENAY 11.2
KOOTENAY BOUNDARY 14.2
COAST GARIBALDI 9.8
UPPER ISLAND/CENTRAL COAST 11.8
CARIBOO 11.2
NORTH WEST 12.5
PEACE LIARD 11.5
BRITISH COLUMBIA 8.3
0 1.0 2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 12.0 13.0 14.0 15.0
Cases per 1,000 population
Source: Discharge Abstract Database
Note: Includes out of province cases.

FINANCIAL SUSTAINABILITY

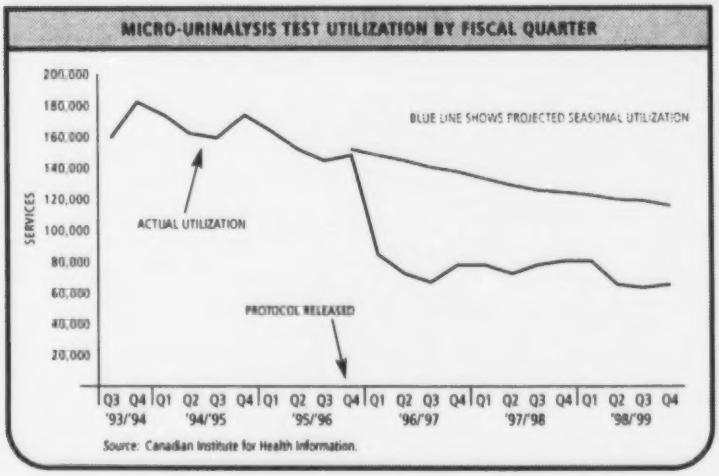
The overall level of health care spending has long been viewed as a sign of the relative health of the system. However, health doesn't necessarily improve just because more is spent on health care, and the fiscal challenges facing all governments make it essential that we make more effective use of health resources rather than simply equating higher spending with success. By reducing unnecessary or inappropriate use of health services, more resources are available for things that do make a positive difference to the health of British Columbians.

This section includes examples of both approaches to measuring success in terms of health spending: an example from the Medical Services Commission of how we can measure the effectiveness of spending and a simple measures of dollars spent.

The Effect of Protocols and Guidelines

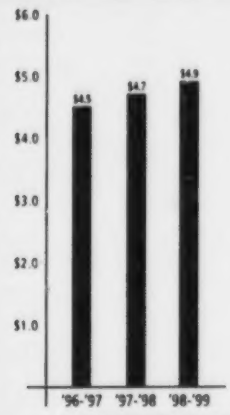
The Medical Services Commission (MSC) has adopted protocols and clinical practice guidelines that reduce unnecessary or inappropriate use of doctors' services, thereby making more resources available for services that make a real positive difference to people's health.

The Protocol and Guideline Initiative is an example of the ministry working with physicians, surgeons and other medical practitioners to review the best available information on appropriate care for common situations, and providing that information to practitioners. The effectiveness of this approach is shown in the graph below:



BY REDUCING UNNECESSARY OR INAPPROPRIATE USE OF HEALTH SERVICES, MORE RESOURCES ARE AVAILABLE FOR THINGS THAT DO MAKE A POSITIVE DIFFERENCE TO THE HEALTH OF BRITISH COLUMBIANS.

ESTIMATED REDUCED EXPENDITURES DUE TO GUIDELINES AND PROTOCOLS



Source: Management Support Branch, Strategic Planning and Development, Medical Services Plan, August 17, 1999.

This chart shows that a new protocol for urine testing reduced the number of microscopic tests that needed to be carried out. This was accomplished by recommending that laboratories do microscopic tests only when macroscopic tests were positive or when ordered by physicians for specific reasons, rather than routinely. This freed up resources for other needed medical services.

There are 28 protocols and guidelines currently in effect, covering a wide range of medical services, such as routine pre-operative testing and prenatal ultrasound.

While not all protocols and guidelines result in reduced costs, the overall impact of this initiative has been a more appropriate use of resources.

The MSC and the BCMA are currently working on further guidelines to maintain this initiative. These include the diagnosis and management of sore throat and the use of homocysteine measurement in the evaluation of heart disease.

B.C. Government Health Care Spending

The following charts present the amount spent on health care in British Columbia in 1997/98 and 1998/99, from several perspectives. Ministry expenditures increased by 4.4 per cent during 1998/99, to $7.383 billion. However, the Ministry of Health is not the only ministry of government that spends money on health care; the third column shows that other ministries spent an additional $367 million on health care, based on data from the Canadian Institute for Health Information (CIHI). For the same time period, CIHI data also lets us examine the levels of other public sector expenditures (consisting of municipal and federal government direct spending on health care, as well as Workers' Compensation Board expenditures) and private sector (commercial and not-for-profit insurance plans, and out-of-pocket expenses) contributions to total health care spending.

HEALTH CARE SPENDING IN B.C. (DOLLARS PER PERSON) 1997/98 – 1998/99

	MINISTRY OF HEALTH	OTHER BC GOVERNMENT MINISTRIES	OTHER PUBLIC SECTORS	PRIVATE	TOTAL
1997/98	$1,781	$92	$130	$742	$2,746
1998/99	$1,836	$87	$132	$762	$2,818
			PERCENTAGE CHANGE (%)		
1998/99	3.1%	-5.4%	1.8%	2.6%	2.6%

Source: Canadian Institute for Health Information.

HEALTH CARE SPENDING IN B.C. (MILLIONS OF DOLLARS) 1997/98 – 1998/99

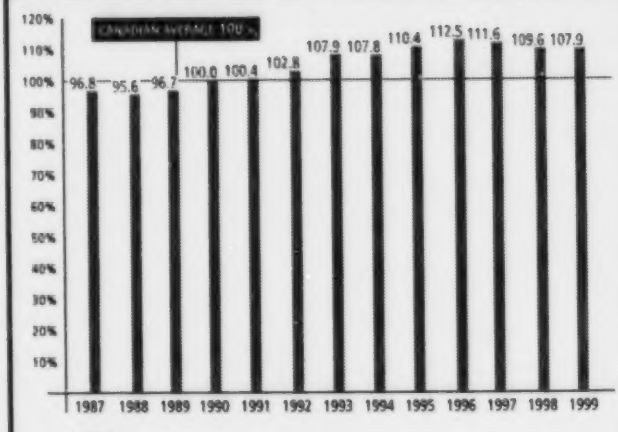
	MINISTRY OF HEALTH	OTHER BC GOVERNMENT MINISTRIES	OTHER PUBLIC SECTOR	PRIVATE	TOTAL
1997/98	$7,074	$364	$516	$2,949	$10,906
1998/99	$7,383	$350	$532	$3,064	$11,330
		PERCENTAGE CHANGE (%)			
1998/99	4.6%	-4.4%	3.1%	3.9%	3.9%

Source: Canadian Institute for Health Information

National Comparison

The following table shows British Columbia's per person spending on health as a percent of the canadian average. It shows that, over this 13-year period, B.C. moved from below the Canadian average to consistently above average in health spending.

B.C GOVERNMENT HEALTH SPENDING PER PERSON AS A PERCENTAGE OF CANADIAN AVERAGE, 1987-1999



Source:

Note: Figure for 1998 and 1998 are projections.

MINISTRY EXPENDITURES INCREASED BY 4.4 PER CENT DURING 1998/99, TO $7.383 BILLION.

PROTECTING MEDICARE AND ESSENTIAL HEALTH SERVICES

- **Increased Health Care Funding** – The ministry budget was increased by $228.5 million, with $63 million of that new funding directed to hospitals. Increases included:
  - $37 million (12.5 per cent increase) for adult mental health.
  - $9.3 million (seven per cent increase) for emergency health services to improve the provincial ambulance fleet's ability to respond to urgent health needs.
  - $11 million (eight per cent increase) for public and preventive health services to expand early intervention and prevention activities.
  - $66 million (16 per cent increase) for Pharmacare to ensure British Columbians can continue to afford the prescription drugs they need.
- **Funding to Reduce Waiting Times** – Several measures were taken during the year to address waiting times. These included:
  - $8.5 million in additional funding was provided to reduce waiting times for cardiac procedures.
  - $10 million in new funding was provided to reduce backlogs of patients by providing additional long-term-care beds and increased operating time.
  - Magnetic Resonance Imaging (MRI) services received funding for a 55 per cent increase in examinations, to keep pace with growing demand.
  - Nearly 800 more surgeries will be performed at B.C.'s Children's Hospital every year as a result of $3.25 million in new funding.

- **Expanded Cancer Treatment** – The ministry took several steps to expand cancer treatment across the province:
  - A new cancer clinic for the Southern Interior opened in Kelowna. It will treat 2,800 patients per year when fully operational.
  - The British Columbia Cancer Agency received a funding increase of $4.6 million to cover the cost of new and improved drug therapies.
  - The ministry provided the B.C. Cancer Agency with $500,000 to support the first year of brachytherapy (implanted radioactive seeds) for the treatment of prostate cancer.
- **Mental health reform** – Achievements include
  - Development of an implementation framework for the new Mental Health Plan; establishment of a Mental Health Implementation Steering Committee; review of existing advisory councils; identification of priorities for new funding; and preliminary work on elements to monitor system performance;
  - To begin implementation of the Mental Health Plan, health authorities were asked to submit plans to address the priority areas: alleviating pressure in acute care hospitals and Riverview Hospital, providing improved responsiveness to people with mental illness and addressing the needs of people with mental illness who are in conflict with the law.
  - The Office of the Mental Health Advocate for British Columbia was created and Nancy Hall was appointed, effective October 1, 1998.
  - The ACCESS Project was initiated to fund the transfer of patients ready for discharge from Riverview Hospital and the Forensic Psychiatric Institute to appropriate community settings.
  - In July 1998, the *Mental Health Amendment Act* was passed by the legislature with the goal of reducing repeated hospitalizations for people with serious mental illness, strengthening patients' rights and improving communication with families.
  - Consultation and planning occurred for the use of $5.7 million in one-time only funding for projects to assist with the transition to the new Mental Health Plan.
- **Forensic Psychiatric Services** – Progress was made in several areas:
  - The commission assumed responsibility for assessing dangerous and long-term offenders.
  - The Mental Health Plan called for greater integration of forensic psychiatric services with other elements of the mental health system and also enabled Forensic Psychiatric Services to hire 30 full-time equivalent forensic liaison workers to assist in the decriminalization of mentally disordered offenders.

- The Mental Health Plan also addressed the governance of Forensic Psychiatric Services and it is anticipated that the operations of the service will be transferred from the ministry to the commission.

- **Improved Organ Donation System** – Amendments to the *Human Tissue Gift Act* were introduced to allow the government to draft protocols to ensure opportunities to receive organ donations are not missed.

- **New Health Care Equipment** – The ministry provided health authorities across the province with $26 million in new funds to replace existing equipment including CT Scanners, cardiac catheterization labs, radiotherapy equipment, patient monitoring systems, and other x-ray machines and medical equipment.

- **Improved Air Ambulance Service** – Safety and comfort for patients was improved with the awarding of new air ambulance contracts by the B.C. Ambulance Service. The multi-year contracts, worth approximately $13.5 million, affect BCAS fixed-wing air ambulance and helicopter bases.

- **Community Care Improvements** – The ministry moved quickly to implement the 64 recommendations of the report, "Community Care Facilities: A Focus on Licensing", which re-affirmed the need for licensing, and highlighted its importance in ensuring the health and safety of vulnerable individuals in care.

- **Expanded Renal Services** – Funding for provincial renal services grew by 13 per cent to $52 million. These services are comprehensive to people with chronic renal insufficiency and include all types of dialysis, supplies and drugs.

- **Hepatitis C** – The ministry played a major role in working toward settlement of the 1986-1990 Hepatitis C litigation.

PROMOTING GOOD HEALTH

- **Self-care Pilot Produces Results** – Partnerships for Better Health, a pilot project designed to explore the effectiveness of providing individuals and families with health information to assist with personal health care decisions, completed its first of two years. Results showed a high readership of the self-care materials with the majority of participants indicating an increase in knowledge and confidence in dealing with minor health problems through self-care.

- **Tobacco Strategy** – A variety of steps were taken to reduce tobacco use and its impact on the health of British Columbians:

  - The ministry toughened its enforcement measures aimed at retailers.

  - The minister released lists of what Canadian tobacco companies put in cigarettes. B.C. is the first jurisdiction in the world to require detailed testing and reporting on tobacco smoke.

THE MAJORITY OF PARTICIPANTS INDICATED AN INCREASE IN KNOWLEDGE AND CONFIDENCE IN DEALING WITH MINOR HEALTH PROBLEMS THROUGH SELF-CARE.

- The ministry, in partnership with the Ministry of Education, developed and distributed grade six and seven lessons of *bc.tobaccofacts*, a school-based tobacco prevention program.
- To address the high prevalence of smoking among B.C.'s aboriginal population, the ministry began consulting with the aboriginal community in preparation for an aboriginal tobacco reduction strategy.
- The government launched a precedent-setting lawsuit to recover tobacco-related health costs from tobacco companies.
- The ministry and the World Health Organization (WHO) hosted a major meeting of public health experts on international tobacco control.

■ **HIV/AIDS** – Several key initiatives were introduced during the year:

- The minister presented *British Columbia's Framework for Action on HIV/AIDS*, which outlined core principles, objectives, roles and responsibilities and next steps in addressing the HIV/AIDS epidemic.
- Following the release of the framework, the ministry declared HIV/AIDS a provincial strategic initiative and required health authorities to develop HIV/AIDS plans.
- A planning process was started for the devolution of contracts for HIV/AIDS services to health authorities.
- $10.8 million in HIV/AIDS contracts were renewed for community based services, consistent with the goals and objectives of the framework and with increased programming accountability.
- The Interministry Committee on HIV/AIDS was expanded to ensure representation of relevant provincial ministries.
- A coordination and liaison capacity was established within the Red Road Society, whose mandate is to oversee the rollout of *The Red Road: Pathways to Wholeness*, a British Columbia Aboriginal AIDS Strategy.

■ **Epidemiology** – The ministry made progress in several areas:

- Contingency planning was initiated for pandemic influenza.
- An outbreak of Yersinia pseudotuberculosis associated with milk consumption was investigated.
- Communicable disease surveillance data was posted on the ministry's intranet site so health officials will have immediate access to leading edge information.

■ **Immunization** – There were several significant accomplishments during the year:

- The ministry began offering pneumococcal vaccine to all persons 65 years of age and older, to protect against pneumococcal bacteria, which is an important cause of pneumonia and serious illness in elderly people.

- The hepatitis A immunization program received funding for expansion, resulting in a significant reduction in the number of cases. An immunization program was also initiated for injection drug users and those with Hepatitis C;
- An electronic immunization record system was implemented to boost child immunization levels by improving the ability of health officials to track who has and hasn't been immunized.

- **Injury Prevention** – The ministry began funding the B.C. Injury Research and Prevention Unit, which coordinates efforts to prevent and reduce injuries and their consequences.
- **Eating Disorders** – Federal funding was obtained for the Eating Disorders in Northern British Columbia project, which will test and evaluate a new way to prevent and treat eating disorders among young people in northern B.C.
- **Mammography Expansion** – The Screening Mammography Program of BC continued to expand. Four new centres were added, bringing the total to 30. Additional funding of $1.27 million allowed an additional 26,100 mammograms to be performed, for a yearly total of 202,000 exams.
- **Seniors' Nutrition** – The minister announced that British Columbia would conduct Canada's first survey of the dietary habits of people aged 75 to 84 during the United Nations International Year of Older Persons. The study will be part of a comprehensive survey of the dietary habits of British Columbians.
- **Provincial Health Officer Reports** – The Provincial Health Officer released two major reports:
  - HIV, Hepatitis, and Injection Drug Use in British Columbia - Pay Now or Pay Later? – This special report contained recommendations on ways to reduce deaths and infections from injection drug use.
  - Provincial Health Officer's Annual Report 1998. Feature Report: Immunization– This report focussed on immunization programs in British Columbia – what we are aiming to achieve, how well we are doing, and what improvements are possible in the future.
- **PharmaNet expansion** – Regulations under *The Pharmacists, Pharmacy Operations and Drug Scheduling Act* were amended to give doctors in emergency rooms access to the PharmaNet pharmacy computer network.
- **Drinking Water** – The Office of the Auditor General released a report on Protecting Drinking Water Sources. The ministry began working with agencies identified in the report as having an interest in water quality, to ensure that safe drinking water continues to be a priority.

BRITISH COLUMBIA WOULD CONDUCT CANADA'S FIRST SURVEY OF THE DIETARY HABITS OF PEOPLE AGED 75 TO 84 DURING THE UNITED NATIONS INTERNATIONAL YEAR OF OLDER PERSONS

AS OF MARCH 1999, 29 PER CENT OF B.C. RESIDENTS ENROLLED WITH MSP WERE RECEIVING SOME LEVEL OF ASSISTANCE WITH THEIR HEALTH CARE PREMIUMS.

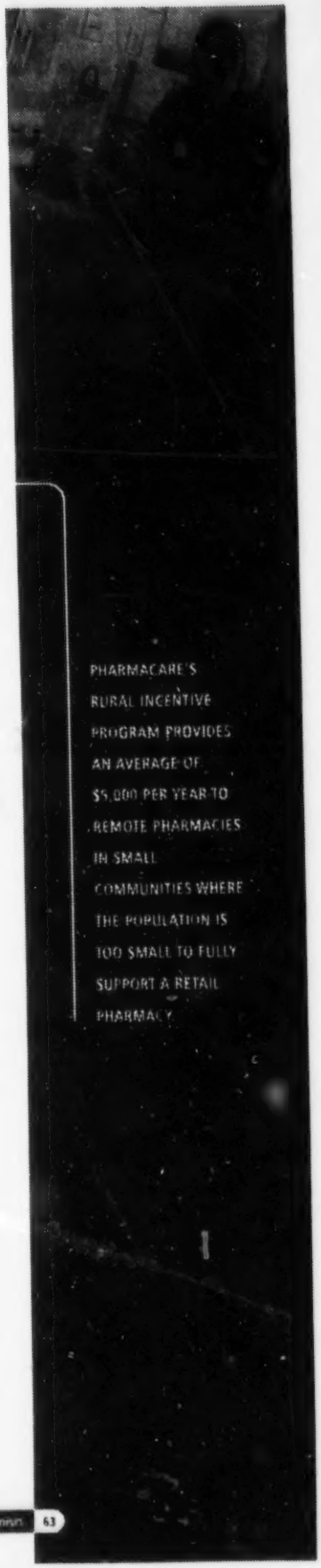
- **Food Inspection** – The ministry initiated discussions with the newly-created Canadian Food Inspection Agency to clarify roles and responsibilities for food inspection in British Columbia.
- **Public Health Information** – Major steps forward were taken:
  - The Public Health Information System (PHIS) was transferred from the ministry to the British Columbia Centre for Disease Control Society (BCCDCS). BCCDCS assembled a plan to implement PHIS across the province. Six additional health authorities undertook PHIS.
  - In cooperation with the major private laboratories, information on demographics and test requests that is gathered by the private labs when specimens are provided is now transferred electronically to BCCDCS.
- **Action on Autism** – The ministry participated in the development of an Inter-Ministerial Action Plan on Autism. The ministry is reviewing support services to adults and initiatives to enhance the regions' capacity to manage autism.

IMPROVING ACCESS TO HEALTH CARE FOR POPULATIONS AT RISK OF POOR HEALTH

- **Increase in Medical Services Plan Premium Assistance Levels** – In order to make sure that level of income does not limit the access of British Columbians to publicly funded health care, the ministry provides Medical Services Plan premium assistance to lower income British Columbians. The adjusted net income ceilings to qualify for the various subsidy levels available under the program were increased on July 1, 1998 by $1,000 each. This enhancement resulted in thousands of recipients qualifying for a higher level of subsidy and enabled more people to become eligible for the program. As of March 1999, 29 per cent of B.C. residents enrolled with MSP were receiving some level of assistance with their health care premiums.
- **Progress on Meeting Remote and Rural Health Needs** – Several key steps were taken to address the needs of British Columbians living in remote and rural areas:
  - The Provincial Coordinating Committee on Remote and Rural Health Services was established to co-ordinate information and actions on health care delivery in remote and rural communities and make recommendations to the ministry.

- The government asked health care consultant Lucy Dobbin to make recommendations aimed at relieving pressures on health care services in B.C.'s remote and rural areas, accepted her recommendations, and acted quickly to implement them.
- The ministry funded RN First Call, a pilot project to train 229 RNs in rural hospital emergency departments to triage and treat a limited number of specific minor medical emergency situations without requiring physician attendance.
- Pharmacare's Rural Incentive Program provides an average of $5,000 per year to remote pharmacies in small communities where the population is too small to fully support a retail pharmacy. Since its creation in 1994, the number of pharmacies covered by the program has grown from 19 to 25.
- The Northern and Isolation Allowance Program provides a fee premium for physicians who live, work and take calls in 103 rural and isolated communities. The allowance was paid to 324 physicians in 1998/99.
- The Emergency Medical Coverage Program provides on-call stipends and enhanced continuing medical education funds to family doctors and general practice specialists in rural and remote communities. In 1998/99, 71 B.C. communities received support through the program.
- The Northern and Isolation Travel Assistance Program provides funding to defray direct travel and accommodation costs plus an honorarium for specialists who travel to 30 rural and isolated communities to hold special clinics. In 1998/99, the program funded 974 visits.
- Health Match B.C. is a recruitment program designed to help rural and remote communities recruit and retain health professionals. In the first three months of 1999, 19 physicians were recruited through the program.
- The Northern and Rural Locum Program was established to assist physicians practicing in small communities to secure subsidized vacation relief. The program supported 2,213 locum days in 210 assignments during 1998/99.

- **Aboriginal Health** – The ministry developed a framework for a Provincial Aboriginal Health Services Strategy, which will be developed in partnership with the aboriginal community.
- **Drug coverage for mental health patients who are in the labour market** – Pharmacare provides clients of mental health centres with psychiatric medications at no charge. This allows lower income working people to get the medications they need and stay in the labour market. In 1998, 8,027 clients received this coverage, up from 6,523 the year before.



PHARMACARE'S RURAL INCENTIVE PROGRAM PROVIDES AN AVERAGE OF $5,000 PER YEAR TO REMOTE PHARMACIES IN SMALL COMMUNITIES WHERE THE POPULATION IS TOO SMALL TO FULLY SUPPORT A RETAIL PHARMACY

THE ACCOUNTABILITY FRAMEWORK FOR BRITISH COLUMBIA HEALTH AUTHORITIES OUTLINES THE RELATIONSHIPS, EXPECTATIONS AND ACTIVITIES THAT CONSTITUTE HEALTH AUTHORITY AND MINISTRY ACCOUNTABILITY.

- **Interpreter Services** – The ministry introduced a program to provide 24-hour access to interpreter and intervener services for British Columbians who are deaf, deaf-blind or hard of hearing and require medical care.

ESTABLISHING A STRONG AND EFFECTIVE GOVERNANCE AND DELIVERY SYSTEM

- **Health Authority Accountability** – The ministry distributed *Accountability Framework for British Columbia Health Authorities*, which outlines the relationships, expectations and activities that constitute health authority and ministry accountability. The ministry also developed *Requirements for Health Service Plans*, which provides health authorities with the ministry's detailed expectations regarding health service planning.
- **Health Authority Board Members** – The ministry provided funding for the training and orientation of health authority board members. The first nomination and appointment process was completed for more than 600 board members.
- **College of Occupational Therapists** – A new college was established to regulate the practice of occupational therapy, formally recognize the profession and give the public confidence in its services.

REJUVENATING THE HEALTH CARE SYSTEM TO ENSURE ITS LONG-TERM SUSTAINABILITY

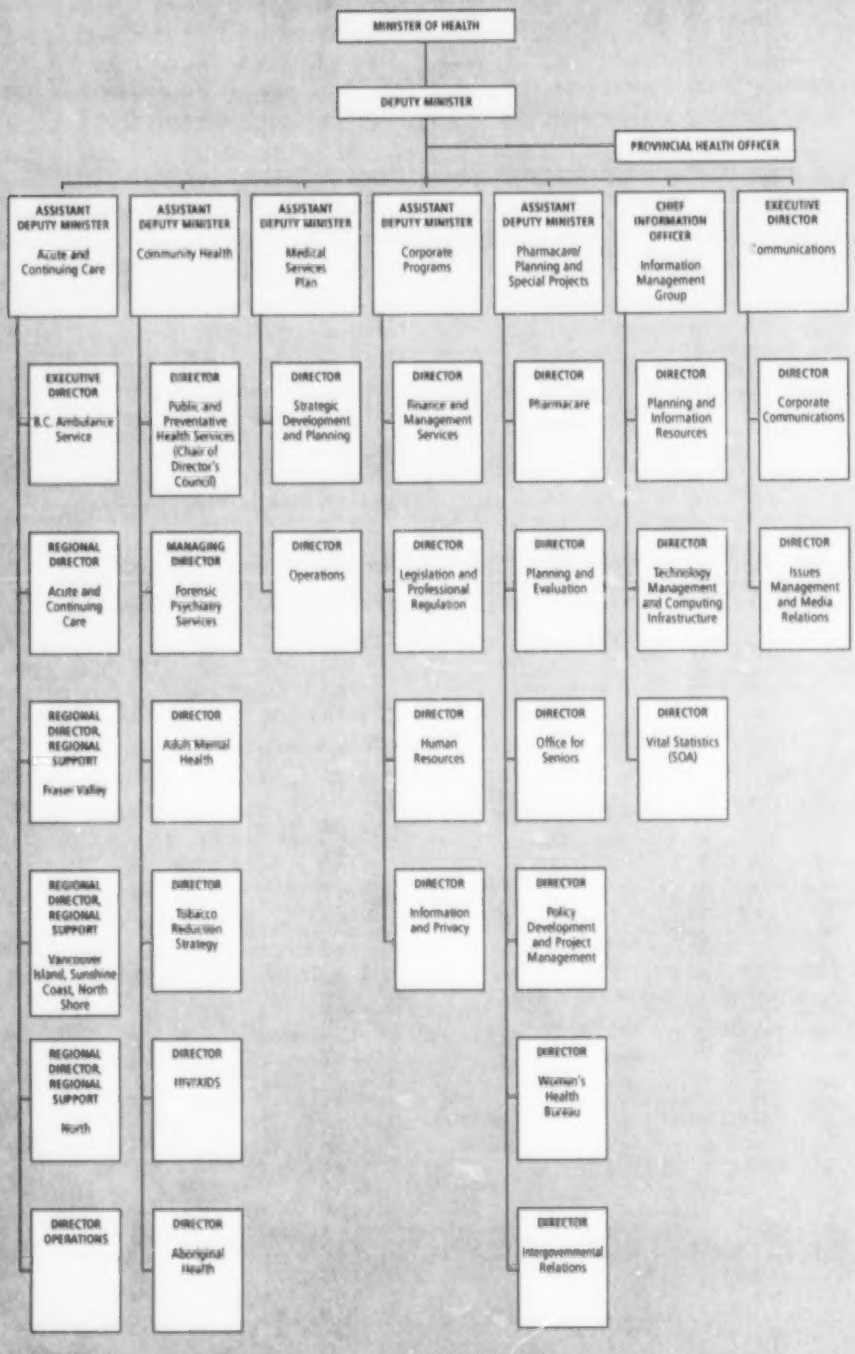
- **Capital Projects** – A wide range of capital projects were undertaken to make sure needed health facilities will be there when British Columbians need them:
  - Approval was given for $38.1 million in completion funds for the replacement of the West Coast General Hospital in Port Alberni, $62 million for the construction of a new patient care tower at Surrey Memorial Hospital, $28.5-million for expansion of the Children's and Women's Health Centre and $14-million for the redevelopment of Royal Inland Hospital in Kamloops.
  - Planning funds were approved for the Vancouver Hospital and Health Sciences tower completion, the replacement of Rotary Manor in Dawson Creek, a new Clearwater Health Centre and two Queen Charlotte Island health centres.
  - Work was completed on a $16 million community health centre and expansion of Mill Site Lodge in 100 Mile House.
  - Work was completed or funds approved for a number of capital projects to improve health care services for seniors. These include 227 beds opened in Osoyoos, Abbotsford and North Vancouver, approval of completion funds for another 170 beds and planning funds for a multilevel care facility in Vancouver's Chinatown.

- Funds of $1.94 million were approved to replace nurse call systems at facilities in Burnaby, Delta, Kamloops, Penticton, Vernon and Victoria.
- Renovation funds totalling $580,000 were approved for Tom Uphill Memorial Home intermediate care facility in Elk Valley, and $900,000 for Tahsis Hospital.
- A $1.4 million eight-station renal dialysis service was opened at Surrey Memorial Hospital.
- New emergency generators were approved at Tofino Hospital, Ladysmith & District General Hospital and Kelowna General Hospital.
- At Chetwynd General Hospital seven beds were approved to be converted to multi-level care standards.
- A new facility will be built on the Fairfield Health Centre site in Victoria, replacing the Mount St. Mary Hospital extended care facility.
- Health care facilities across the province received funding for a variety of capital improvement projects.

- **Primary Care Demonstration Project** – The ministry implemented the Primary Care Demonstration Project to test new and innovative ways of delivering primary health care.
- **Midwifery** – Regulated midwifery entered its second fiscal year with approximately 50 midwives providing care for women during the prenatal, labour and delivery and postpartum stages of pregnancy. In 1998/99, there were 1,013 midwife-attended births in B.C., out of 42,510 total live births.
- **Health Information Infrastructure** – Through the HealthNet/BC project, the ministry is developing the information technology infrastructure to enable the secure transmission of sensitive health information over the internet. This will improve care for patients by providing hospitals and doctors with faster access to lab results and other important patient information.
- **Health Registration** – Changes are being made in the computer systems that maintain records of individual registration for publicly funded health care and MSP premium status. When these changes are completed, hospitals will be better able to check on patient eligibility for publicly funded health care, and employers who administer MSP premiums on a group basis will be able to directly carry out functions such as adding beneficiaries.

ENABLING SECURE TRANSMISSION OF SENSITIVE HEALTH INFORMATION OVER THE INTERNET WILL IMPROVE CARE FOR PATIENTS BY PROVIDING HOSPITALS AND DOCTORS WITH FASTER ACCESS TO LAB RESULTS AND OTHER IMPORTANT PATIENT INFORMATION

APPENDIX 1 – MINISTRY ORGANIZATIONAL CHART



March 1999

APPENDIX 2 –

ACTS AND PROFESSIONS UNDER THE JURISDICTION OF THE MINISTER OF HEALTH AND MINISTER RESPONSIBLE FOR SENIORS.

ACTS

Access to Abortion Services Act
Anatomy Act
Chiropractors Act
Community Care Facility Act
Continuing Care Act
Dentists Act
Forensic Psychiatry Act
Health Act
Health Authorities Act
Health Care (Consent) and Care Facility (Admission) Act (not in force)
Health Emergency Act
Health Professions Act
Health Research Foundation Act
Health Special Account Act
Hearing Aid Act
Hospital Act
Hospital (Auxiliary) Act
Hospital District Act
Hospital Insurance Act
Human Tissue Gift Act
Marriage Act
Meat Inspection Act
Medical Practitioners Act
Medicare Protection Act
Mental Health Act
Ministry of Health Act
Name Act
Naturopaths Act
Nurses (Registered) Act
Nurses (Registered Psychiatric) Act
Optometrists Act
Pharmacists, Pharmacy Operations and Drug Scheduling Act (except Part 8)
Podiatrists Act
Psychologists Act
Public Toilet Act
Seniors Advisory Council Act
Tobacco Damages and Health Care Costs Recovery Act
Tobacco Fee Act (not in force)
Tobacco Sales Act
Venereal Disease Act
Vital Statistics Act
Wills Act (Part II) Acupuncturists

PROFESSIONS

Chiropractors
Dental Hygienists
Dental Technicians
Dentists
Denturists
Emergency Medical Assistants
Hearing Aid Dealers (including audiologists in private practice)
Licensed Practical Nurses
Massage Therapists
Medical Practitioners
Midwives
Naturopaths
Occupational Therapists
Opticians
Optometrists
Pharmacists
Physical Therapists
Podiatrists
Psychologists
Registered Nurses
Registered Psychiatric Nurses

APPENDIX 3 – 1998 LEGISLATIVE CHANGES

Thirteen Acts administered by the ministry were passed, amended or repealed during the 1998 Sitting of the Legislative Assembly. The most significant changes were:

MENTAL HEALTH AMENDMENT ACT, 1998 (BILL 22)

A number of amendments were made in support of the government's Mental Health Plan. These amendments:

- modified the criteria for involuntary admission and treatment;
- clarified the factors to be considered by doctors, Review Panels and courts on the renewal or continuation of involuntary treatment;
- changed the involuntary admission process to require only one medical certificate for initial admission and treatment for up to 48 hours;
- changed the criteria for obtaining a court warrant for apprehension of persons with a mental disorder;
- established the right of involuntary patients to request a second medical opinion on the appropriateness of their psychiatric treatment;
- entrenched in the Act are the rights, including Charter rights, of all involuntary patients; and,
- added new procedural protections for involuntary patients receiving long-term treatment in the community.

TOBACCO SALES AMENDMENT ACT, 1998 (BILL 28)

Several amendments were made to strengthen the ability of government and health authorities to protect children from tobacco. These amendments:

- increased by five times the maximum fines for convictions under the Act;
- doubled the length of suspension periods that result from receiving multiple convictions under the Act;
- added a new requirement that suspended retailers must post a sign in their stores giving the public notice of the suspension;
- added a provision that convictions under the federal Tobacco Act will also be counted when imposing suspensions; and
- clarified government's authority to make regulations requiring disclosure of information regarding tobacco products.

TOBACCO FEE ACT (BILL 29)

This new Act established the authority of government to collect a license fee from tobacco manufacturers whose products are sold in British Columbia and make up more than a five percent share of the total market in the province. (Act is not in force).

TOBACCO DAMAGES RECOVERY AMENDMENT ACT, 1998 (BILL 30)

The purpose of the Tobacco Damages Recovery Act was to assist government and individuals in British Columbia to recover the costs of tobacco related illnesses through legal claims. These amendments:

- change the title to Tobacco Damages and Health Care Costs Recovery Act, to emphasize the distinction between damages and the recovery of the costs of health care benefits;
- clarify that government may bring a direct aggregate claim in its own right for the cost of health care benefits, and need not rely on the claims of individuals;
- shift the onus of proof to tobacco manufacturers by establishing, once government proves ertain elements of causation, a rebuttable presumption that manufacturers are liable for the cost of health care benefits involved in the treatment of tobacco-related illness;
- establish a rebuttable presumption that liability is apportioned according to a manufacturer's market share;
- clarify that proof of an aggregate claim may be based on statistical or epidemiological evidence; and
- clarify definitions to prevent manufacturers from avoiding liability through different corporate structures.

NURSES (REGISTERED PSYCHIATRIC) ACT

This Act was repealed under the *Regulatory Streamlining Miscellaneous Statutes Amendment Act, 1998* (Bill 44). Registered psychiatric nurses will now be regulated under the *Health Professions Act*.

APPENDIX 4 – MINISTRY EXPENDITURE STATEMENT

MINISTRY OF HEALTH EXPENDITURES BY PRINCIPAL PROGRAMS

	1997/98 ACTUALS	1998/99 ACTUALS
Emergency Health	131,709,000	137,988,000
Adult Mental Health	292,234,000	326,582,000
Public and Preventive Health	133,136,000	137,871,000
Acute and Continuing Care	3,922,786,000	4,129,236,000
MSP	1,768,417,000	1,847,504,000
Pharmacare	468,094,000	504,258,000
Debt Servicing	174,466,000	173,947,000
Other	182,973,000	126,006,000
Total	**7,073,815,000**	**7,383,392,000**
BC Transit	288,640,000	0
Grand Total	**7,362,455,000**	**7,383,392,000**

NOTES:

1) Expenditures for 1997/98 have not been restated to reflect major program reallocations and are presented here for comparative purposes only.

2) Other includes: Minister's Office, Corporate Services, Vital Statistics, Medical Health Care Special Account, Statutory Expenditures and adjustments for the capitalization of assets and depreciation expense.

3) Figures are per Public Accounts publication and refer to Ministry of Health expenditures only. Health related expenditures undertaken by other ministries are excluded from this schedule.

APPENDIX 5 – MEDICAL SERVICES COMMISSION

STATEMENT OF OPERATIONS

MEDICAL SERVICES COMMISSION STATEMENT OF OPERATIONS
FOR THE YEAR ENDED MARCH 31, 1999 (UNAUDITED)

(THOUSANDS OF DOLLARS)	1999	1998
EXPENDITURE		
Service Costs	$	$
Medical Care	1,699,443	1,632,023
Supplementary Care	120,938	110,534
	1,820,381	1,742,557
Administration		
General Office	6,573	6,629
Salaries	20,550	19,232
	27,123	25,861
	1,847,504	1,768,418
CONTRIBUTIONS (Note 3)		
Premium Revenue	876,047	881,826
Premium Assistance	359,225	355,512
General Contributions	612,232	531,080
	1,847,504	1,768,418

The accompanying notes are an integral part of this financial statement.

Approved on behalf of the Commission:

Martin S. Serediak, PhD
CHAIR, MEDICAL SERVICES COMMISSION

MEDICAL SERVICES COMMISSION NOTES TO FINANCIAL STATEMENT

1. THE COMMISSION

The Medical Services Commission was established, effective July 1, 1968, by the Government of the Province of British Columbia under the *Medical Service Act* and Regulations, to administer and operate the Medical Services Plan.

The legal authority for the Medical Services Commission to administer and operate the Medical Services Plan is the *Medicare Protection Act.*

Under Section 5(4) of the *Medicare Protection Act*, the Commission is a division of the Ministry of Health and Ministry Responsible for Seniors. Medical Services Plan premiums and expenditures are included within the Province's Consolidated Revenue Fund Statement of Revenue and Expenditure, which is audited annually by the Auditor General of British Columbia.

2. SIGNIFICANT ACCOUNTING POLICIES

The Statement of Operations is prepared for the purpose of presenting the expenditures of the Plan and contributions by subscribers and the Province.

The expenditures and contributions are recorded on an accrual basis.

The cost of furniture and equipment is charged to administration expense in the year of acquisition.

The Province of British Columbia pays certain administration, accommodation, data processing and systems salary costs associated with the operation of the Commission.

Service costs include payments for eligible services provided by medical practitioners and other health care practitioners on a fee for service basis according to fee schedules approved by the Commission, and payments on a contract, salaried or sessional basis. The expenditures include estimates of claims, for services performed in the year, that were unpresented or unprocessed at March 31, 1999.

3. CONTRIBUTIONS

Premium revenue consists of the Medical Services Plan premiums paid by subscribers.

Premium assistance represents the value of subsidy provided by the Province on behalf of eligible persons.

General contributions represent the net amount paid by the Province to fully meet the expenditure of the Commission.

APPENDIX 6 – REVENUE AND ACCOUNTS RECEIVABLE PROGRAMS

MEDICAL SERVICES PLAN

Collection of Overdue Premiums Receivable

FISCAL YEAR	TOTAL REVENUE	OVERDUE ACCOUNTS BILLED	COLLECTIONS*	WRITTEN OFF	UNDER COLLECTION MARCH 31
1998/99	$876,047,000	$60,495,000	$44,242,000	$613,284	$54,896,000
1997/98	881,826,000	54,384,000	33,652,000	196,000	30,400,000
1996/97	853,262,000	35,338,000	15,450,000	116,000	12,900,000

Aging of MSP Premiums Receivable

FISCAL YEAR	TOTAL	CURRENT	30-60 DAYS	60-90 DAYS	90-PLUS
March 31, 1999	$83,973,084	$20,453,668	$7,454,562	$2,725,694	$53,339,160
March 31, 1998	54,913,907	13,682,583	9,187,698	1,679,532	30,364,094
March 31, 1997	29,945,709	12,464,434	4,237,681	1,089,114	12,154,480
March 31, 1996	10,837,342	8,670,422	1,998,408	126,300	42,212
March 31, 1995	10,094,238	7,965,014	1,996,216	93,569	39,439

Collection Program Costs

	1998/99	1997/98	1996/97
Collection Dept Costs	$750,000	$600,000	$500,000
Loan Administration Branch	175,758	182,000	–
Collection Agency Commission	235,164	195,798	165,295
Total Collection Costs[17]	**$1,160,922**	**$977,798**	**$665,295**

BC AMBULANCE SERVICES

Collection of Ambulance Service Fees

FISCAL YEAR	TOTAL REVENUE	OVERDUE ACCOUNTS BILLED	RECOVERIES**	WRITTEN OFF	UNDER COLLECTION MARCH 31
1998/99	$23,496,000	$13,349,000	$7,347,000	$1,880,515	$7,505,200
1997/98	22,445,000	9,542,000	4,818,000	1,645,600	6,512,000
1996/97	18,706,000	7,831,000	4,583,000	1,804,000	5,850,000

Aging of Ambulance Fees Receivable

FISCAL YEAR	TOTAL	CURRENT	30-60 DAYS	60-90 DAYS	90-PLUS
March 31, 1999	$9,488,913	$1,265,355	$408,006	$308,543	$7,507,009
March 31, 1998	10,344,927	2,575,413	954,471	380,966	6,434,077
March 31, 1997	7,878,508	1,100,680	611,135	325,384	5,841,299
March 31, 1996	7,949,575	1,108,115	628,751	389,740	5,822,969
March 31, 1995	7,594,220	1,010,886	718,236	283,857	5,581,241

Ambulance Service Fees Accounts Receivable Turnover

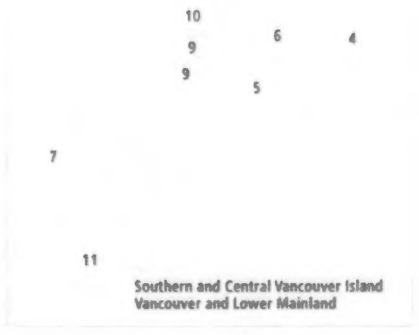
Accounts receivable turnover is one indication of the timeliness of collection. Accounts receivable turnover for ambulance accounts was 4.8 times for fiscal 1998/99, 4.9 times for fiscal 1997/98, 3.6 times for fiscal 1996/97, and 3.4 times for fiscal 1995/96 and fiscal 1994/95. An increase in turnover indicates that ambulance accounts receivable are collected more rapidly.

Days billings uncollected is another indication of the speed of collecting accounts receivable.
1998/99 – 76.0 days; 1997/98 – 74.6 days; 1996/97 – 102.1 days; 1995/96 – 107.1 days; 1994/95 – 105.9 days

**Collections include all premiums paid, plus credit adjustments that reduce indebtedness.*

***Recoveries include all fees paid, plus credit adjustments that reduce indebtedness.*

APPENDIX 7 – REGIONAL HEALTH BOARDS



Southern and Central Vancouver Island
Vancouver and Lower Mainland

REGIONAL HEALTH BOARDS

1. North Okanagan*
2. Okanagan Similkameen
3. Thompson
4. Fraser Valley
5. South Fraser
6. Simon Fraser
7. Central Vancouver Island
8. Northern Interior
9. Vancouver/Richmond
10. North Shore
11. Capital

* Name changed from North Okanagan/Columbia Shuswap to North Okanagan on January 31, 1996

APPENDIX 8 – COMMUNITY HEALTH COUNCILS

Southern and Central Vancouver Island
Vancouver and Lower Mainland

COMMUNITY HEALTH COUNCILS

1. Elk Valley and South Country
2. Cranbrook
3. Kimberley
4. Columbia Valley
5. Creston and District
6. Nelson and Area
7. Castlegar and District
8. Arrow Lakes/Upper Slocan Valley
9. Greater Trail
10. Boundary
11. Golden
12. South Cariboo
13. Central Cariboo Chilcotin
14. Quesnel and District
15. Bella Coola and District Transitional*
16. Sunshine Coast
17. Powell River
18. Sea To Sky
19. Comox Valley
20. Campbell River/Nootka
21. Mount Waddington
22. Central Coast Transitional**
23. South Peace
24. North Peace
25. Fort Nelson-Liard
26. Bulkley Valley
27. Upper Skeena
28. Terrace and Area
29. Kitimat and Area
30. North Coast
31. Queen Charlotte Islands/Haida Gwaii
32. Nisga'a (not designated under the *Health Authorities Act*)
33. Snow Country
34. Stikine

* Name changed from Bella Coola Valley and District to Bella Coola District Transitional Health Authority on March 19, 1998
** Name changed from Central Coast to Central Coast Transitional Health Authority on June 3, 1998

APPENDIX 9 – COMMUNITY HEALTH SERVICES SOCIETIES

Southern and Central Vancouver Island
Vancouver and Lower Mainland

COMMUNITY HEALTH SERVICES SOCIETIES

1. East Kootenay
2. Kootenay Boundary
3. Coast Garibaldi
4. Upper Island/Cental Coast
5. Cariboo
6. North West (excludes Nisga'a)
7. Peace Liard